The Royal College of Physicians and Oxford Brookes University
Medical Sciences Video Archive MSVA 013

Sir John Badenoch in interview with Sir Gordon Wolstenholme
Oxford, 13 June 1986

GW John, I believe that your father was a doctor. Was it always your intention to follow him, when you were at Rugby?

JB Yes, I think so. My father was an Aberdeen graduate, and he was exported down to London, just before the First War. And it was always understood in the family that I would follow in his footsteps. I think, in those days, we didn't get quite so much choice as, perhaps, we do now, but I was quite happy to do this. I never really wanted to do anything else.

GW So at Rugby, you were prepared, so to speak, to go up to Oxford for that purpose, to qualify as…?

JB Yes. Even Oxford was a new venture for my family, because they've all been Aberdeen graduates in the past. And I think my father knew Dr Vaughan,[1] who was the then headmaster, in the early days, and so I went to Rugby. And then from Rugby, as doubtless everybody else did, automatically went to Oxford, without any particular effort on my part. As you know, entrance examination was pretty easy in those days.

GW Fortunately!

JB Yes. And I went to Oriel, and I was very happy there.

GW But your early undergraduate training must have been considerably messed up by the war?

JB Well, it was and it wasn't. I went up to Oxford just before the war, and K J Franklin was the tutor in Oriel, and I had a great deal of time for him. He was a very good tutor in the old Oxford style, yet one often wondered why he was so good, because he didn't seem to do very much, you did it all yourself. I had the year of the phoney war there, and then, as you may remember, the final honours school was scrubbed. We were given our BAs, which, perhaps, was a mercy. And K J said, 'Look, you've got to do something to distinguish yourself from the common herd.' So he made me do two things. He made me enter for a drawing prize, which was disastrous because I'm no draughtsman! I did… I drew a… I think it was a uterus and tubes, but it was a disaster, it didn't look like any uterus and tubes that ever had been. And he said, 'Go and take the primary fellowship,' which I did, and passed. And then, I think, largely through K J's good offices, I got a Rockefeller studentship to the States. That was very nice.

GW And that was '41 or so?

[1] William Wyamar Vaughan (1865-1938). Headmaster of Rugby School, 1921-31.

JB Yes, that was ’41 to ’43. I went to Cornell.

GW And did you do your clinical work at Cornell?

JB Yes. I did my… I did… virtually… I did one firm at the Radcliffe, with old Mr [Douglas Allan] Abernethy the violin maker. He was a good teacher. And then I went to Cornell and spent two years there; took their MD, although officially I was not supposed to, because the British government, I think, had asked that we shouldn’t. And then came back and took the Oxford BM. Actually, I was lucky then, because I’d always been keen on medicine, although I’d taken the primary fellowships, medicine was no problem. Obstetrics was a problem. And what really frightened me was that I was saying what I had been taught and the examiners weren’t liking it. I think obstetrics doesn’t cross the Atlantic too readily. And had it not been for the good offices of the then regius professor, who was [Arthur] Duncan Gardner, who, I gather, followed me around to see this strange animal having his viva, and then interceded on my behalf with the examiners…

GW When you produced American views and…

JB Yes. He explained, I gather, that this chap had just come from the States.

GW How very interesting. I can remember that how, the very first time I went to the States with my wife, and we had a flaming row with the obstetricians, whose views were…

JB Yes. Well, maybe there was a big divergence. I didn’t know enough about the subject to know this. But certainly I had a very uncomfortable feeling that what I was saying wasn’t going down at all well.

GW But all ended well, and you…

JB All was well, yes.

GW And then presumably, you had to do… you went into the army. I mean, you had no choice.

JB No. No, well… well, I got… Geoffrey Dawes and I tied in the final examination, and we both became joint housemen to Professor [Leslie] Witts, and to Dr [Alexander George] Gibson. And that was a splendid time, because these two were a marvellous contrast. I mean, Gibby was an old-fashioned physician, physician pathologist really, with a lot of ancient and hallowed views, but, nonetheless, a very good bedside teacher. And Witts, of course, was a very stimulating person to work with. I was very fond of him. And he did… not only was he marvellous to work for… and in those days, the unit was small, so it was very personal. You know, coffee with him every morning was an absolute delight. But he promised if we… he said we had to join the army, there was a second (service?), or the navy, and he’d have us all back afterwards. And he did, I think. He had every single person who had been through his unit, for a time. And I came back and kind of stuck.

GW Yes. Oxford has been… you’ve…

JB Yes. I had one interlude away. My father died suddenly of leukaemia, not long before the appointed day, about nine months before the appointed day,[2] and I went and ran the practice to hold the goodwill together, because you'll remember that goodwill was quite important in those days, so that my mother would get something from it. And…

GW Was that up in Scotland?

JB No, it was in London.

GW Oh.

JB And then, in fact, I enjoyed the time. I think it was very good for me, subsequently, in being a hospital physician, to have had this experience. I don't think I would have wanted to stay there all my life, because I missed the, you know, the academic end of it from the hospital, but I'm glad I did it.

GW This is before the Health Service came in?

JB Yes. It was immediately before the Health Service, running up to the day when it came in. '48 was it? I can't remember.

GW Yes, '48.

JB Yes, I think so.

GW And by '49, you were really settled in Oxford again.

JB I was back in Oxford then, yes.

GW And if I remember rightly, your first appointment was that of a sort of research assistant, in the Nuffield Department [of Clinical Medicine].

JB Yes. I remained research assistant there for some time. And, in the course of being research assistant, I became director of clinical studies, which is a clinical dean. And that was great fun because that was at a very formative time of the Oxford Clinical School. In fact, it was touch and go whether there was going to be one at all. And I remember fighting very hard for it, believing in it, and thinking it would be a good thing to have. And it was quite difficult, because there were some very powerful people who were not in favour of it, namely Professor [Robert] Macintosh, who was professor of anaesthetics, who felt that the Nuffield benefaction should be used solely for postgraduate affairs, and that to dilute it with an undergraduate school would be a mistake. Witts and Dame Janet Vaughan were in favour of it. But my problem with Witts was that… it was awfully hard, when it came to the crunch, to get him to use his sixteen-inch guns. We could discuss things, and prepare them, and I knew that my pea-shooter wasn't any good. When it came to a major university committee, it had to be the professor's sixteen-inch guns. And yet one could never be quite sure that he'd fire the broadside. He was a very sensitive chap, and later, when regius changed and we

[2] Sir John Badenoch is referring to the start of the National Health Service on 5 July 1948.

got [George] Pickering as regius[3] – and I worked for him also, of course, as clinical dean – I used to think we had a 'priest king' and a 'warrior king', and they were very different people.

GW I think it was a great disadvantage to Leslie Witts. I mean, he… there was a question of going to the MRC [Medical Research Council] wasn't there, and so on, for him.

JB Yes.

GW And he didn't carry that kind of… pugnacity, perhaps, which is…

JB No. I think that's it, really. He was a very sensitive, rather introspective person, but an immense intellect, and very kind. I once did a terrible thing to him. I actually took my father's blood-film slides to him for a second opinion. Donald Hunter was looking after my father in London, and I had a lot of time for Donald. He was very kind to me, and to the family. But, you know, working with Witts, and it being haematology, oncological condition, I thought I'd ask my prof, and Donald didn't mind. But it was a dreadful thing to have done to Witts, because he hated doing this, and he hated…

GW He hated having to give you the answer?

JB Yes. And he hated, above all, having to give it to a friend. And it caused him great distress to have to say, 'Well, I'm sorry, but, you know, they're right, and your father has got leukaemia.' But he once said he gave up private practice in haematology because it meant going around giving death sentences. I mean, all the treatable conditions had been siphoned off by the time they came to…

GW To a haematologist, yes.

JB Well, certainly one of his eminence.

GW Yes. The Undergraduate School, of course, everyone would agree it's not only been a success, but it's been an outstanding success.

JB Yes.

GW What was… what was really, I mean, apart from Robert Macintosh wanting this… the graduate side of it, was there any other opposition?

JB Well, I find this very interesting, because in later years, I helped with the planning of the Cambridge Medical School. And I think that's really why they asked me to do it, because I'd been through the same drill in Oxford. I think it would be fair to say that there was no significant opposition from the pre-clinicals, and that was important. I did once hear the professor of physiology say he thought he had more in keeping with the professor of astronomy than the professor of medicine, but that was an unusual attitude. In general, we got the backing of the pre-clinicals. I think… what

[3] Sir George White Pickering (1904-1980). Regius professor of medicine, University of Oxford, 1956-68.

was more difficult… well, there were two things which were difficult. First of all, the main source of money for the Medical School was the Nuffield benefaction, and the Nuffield Professors as a group were concerned to keep that cash, and I, and others, were concerned to make them disgorge some of it for the good of the common weal, and we had many battles over that. And the second problem was that the Radcliffe Infirmary had always been a… you know, a substantial provincial county hospital. But the physicians and surgeons who were there, were a bit suspicious of this new Clinical School. They were suspicious of the professors…

GW And whether they would have a role to play, I suppose.

JB Well, wondering, you know, how this would make out. And Nuffield, of course, was very wise in providing money to jack up the rest of the hospital, to the standard of his benefaction.

GW He was still alive at that time?

JB Yes. Oh yes.

GW And you knew him personally?

JB Yes. Actually, he was a patient of mine in later years. But from the point of view of the administration, Macintosh interpreted his views, and that was sometimes a problem, because he always purported to know the master's voice, so to speak! I think… I had another interesting example of this, later on, when I was quite senior, there was a gap on the staff, and although I wasn't a consultant, I was a member of the staff council, by virtue of being director of clinical studies – clinical dean – and I was party to the discussions about my appointment, which is really very interesting, because they were very vitriolic, against it. And they were most kind afterwards, and came up to me and said, 'Look, there's nothing personal in this,' they said, 'It's just we don't like the principle. This is the professor appointing consultants, or purporting to appoint consultants, in the hospital. And before we know, they'll have taken over everybody's... But however, in the end, the appointments committee was held, and I think a perfectly straightforward one, and I was lucky enough to get the post. So there was an academic physician, if you like, on the staff. But what interested me more was, when I started to go out into the community and do domiciliary visits and meet people, the doctors said, 'Oh, we thought you lot were just interested in guinea pig minding, you know.' And I said, 'Far from the case. I mean, Professor Witts has always been interested in clinical medicine, and is a first class clinician very, very good clinician.' And I was reminded of it years later, when Sir George Pickering said that his patients, on whom he did his research, were his most devoted friends, and that they could always say, you know, 'My doctor knows more about my condition than anybody else.' And I think that was true of Witts too. I mean, he had many devoted patients. In fact, he used to collect a very strange group of patients. He was interested in psychosomatic medicine, you know, and apart from the straight haematology, he had some very interesting people whom he looked after.

GW Yes. And, of course, he was literate and very artistic and a beautiful writer.

JB Oh yes. I mean, he… I remember one remarkable occasion when, at the postgraduate meeting - and they were rather small in those days, not the big affairs they are now - and the late Phil Bedford was presenting a case of hemiballismus in an elderly lady, and it was perfectly clear to me that Witts didn't know anything about hemiballismus, and the rest of us too. But he managed to turn the conversation round to the epidemics of rock and roll that had swept through Europe in the Middle Ages, and the whole thing was carried off very easily! Or he'd give you a lecture on the Nicene Creed. I mean, these sorts of things that not many professors nowadays are capable of doing.

GW No. That must have been absolutely fascinating.

JB Oh, it was.

GW But your duties as director and dean of clinical studies, or whatever the correct title was, was that immediately arduous? I mean, did you really have to create it, create the role?

JB Well, I wouldn't like to claim the credit for creating it, but I did work very hard to try and make the 'infant school' a success. The difficulty about my post – and I think everybody who has held the post, even to this day, finds this – is that the relationship between yourself and the regius professor, and the professor of medicine, especially now with a very powerful Nuffield professor of medicine, I think this can make for difficulty. I mean, for example, I used to plan things and do things, and Sir George, by virtue of his many commitments, was often away, and then he'd come back and unpick it all. Now, I wouldn't for a moment say he wasn't right, but it would be much easier if we'd worked together, rather than have gone a long way down the road and then unpick it. And, I think, as each holder of that particular office has got more senior, they have felt that they wanted an independent command. And, of course, there's been talk and discussion for years about whether we should have a dean, and if so, what sort of a dean he should be, and should the old mediaeval regius professorship be changed in some way? Because… I mean, he is titular head of a lot of things and it's up to him, I suppose to delegate. But it can be difficult sometimes.

GW Yes. Well, and it's certainly had strong personalities in the post, and…

JB Yes. And very variable ones.

GW And very variable ones.

JB I remember, not quite [Edward Farquhar] Buzzard, I can remember [Arthur Duncan] Gardner, and [Arthur] Ellis from the London Hospital. And then, of course, Sir George [Pickering], and then Richard Doll, and now Henry Harris. They're all very different.

GW Very different.

JB In their own ways, eminent and powerful people. One thing… at about this time, I had the privilege of being, I think, Sir Arthur Hurst's last house physician. He came to Oxford, you know, in his later years, and Witts said, 'Look, look after him'.

Witts had a very soft spot for Sir Arthur Hurst and so had I. And I became a sort of unofficial house physician and also unofficial, I suppose, clinical assistant. I used to look after his private patients. And in his later years, he spent a good deal of time in bed, or near bed, disabled by his asthma, and I remember one day, interviewing a patient for him, you know, I think it was the Acland [Hospital], a very wealthy London businessman who could only eat his meals on all fours. He had to get down, kneel down, and of course, in board meetings and so on, this was very awkward. So I took a history carefully and examined him, went up and saw Sir Arthur. And Sir Arthur said, 'God bless my soul! I've got to see this!' you see. So he got a taxi, and we wrapped him up in rugs, and we took him down to the Acland, and, sure enough, a meal was brought in, and the chap down on all fours, and Sir Arthur got him eating a meal sitting up in one session – I think just by power of personality, because he had the most magnetic personality!

GW Was it through that that one of your major interests became gastroenterology?

JB No, not quite. The interest, really, stemmed from Witts' interest, I think, in what are now called the nutritional anaemias. They're not nutritional in the dietary sense, but nutritional in that the building bricks are taken in by mouth. So we were interested in B_{12} deficiency and iron deficiency and the watershed between gastroenterology and haematology. And we had a… about that time, you may remember that there had been a British Army research team in Poona, working on sprue and Paul Foreman had been a member of that team, and he was working in Oxford at the time with Witts. And so we developed an interest in malabsorption and sprue, in particular, then. And I remember there was a… we had a strong line in nuns, because there was a convent here in Oxford that had a sister convent in India, and the nuns used to get sprue, of course, from time to time, and because of their way of life, they're prone to osteomalacia. And so Paul Foreman and I had a steady series of subjects who (a) had osteomalacia, (b) had plenty of time, (c) were very biddable, and so we were able to do quite a lot of work on these nuns. And I think that, plus Witts' interest in the gut and anaemia, was where I got interested in gastroenterology. But… and then later, of course, I had… in fact, it's funny how things happen. I think I produced a first histological biopsy of a small intestine, taken by mouth. I was working on gastric biopsies, using that old Wood's gastric biopsy tube. And it popped through into the intestine, and I got a lovely picture of the jejunum; it was a patient with a partial gastrectomy, it had gone straight through. And I was able to show this with a paper I gave at the Association of Physicians. And it went down terribly well, and I was frightfully pleased! But there it stopped and I lost impetus, and I think the reason was that I tried it again, and only this time, trying to get it through the duodenum. And I got the tube through the duodenum and into the jejunum, and it wouldn't come back.

GW This was not a gastrectomy case, of course.

JB No, no. It wouldn't come back. And our then senior radiologist, [Frederick Harold] Kemp, having looked at the pictures, said, 'I don't think you'll ever get this out again.' And, of course, that frightened me a bit! But, in fact, if I'd thought about it, even though it was biting on to the mucosa, if you give it a few minutes, it'll bite it off, it'll rot away. So it came up all right. But it rather destroyed my interest in doing this. I think Witts had frightened me…

GW How long after that did the instrument which enables it to be done, how long after…?

JB Oh not long after. It was a matter of a year or so, I think it was. But, of course, it was an immense advance. It is a great advance, really. But the small intestine is a difficult field to study, and still eludes us. And a lot of it is…

GW But the changes are so dramatic when you get these biopsies, aren't they, in these conditions?

JB Yes. Yes. Although, unhappily, in coeliac disease, of course, is still a biopsy by exclusion, which is difficult. I mean, you look for things that you can diagnose, and then if you can't diagnose them in flat patterns, diagnostic is coeliac disease.

GW What about your teaching role in Oxford?

JB Well, of course, being on Witts' team, we were teaching all the time. I've always enjoyed bedside teaching. And I think, best of all, I enjoy the first year students. I like teaching them physical diagnosis, and in later years, of course, I also liked to teach them a little bit of… you know, the way I look at patients, I think, because I've been interested in communication with patients. And I think we've been privileged to have an exceedingly good batch of students for the last ten or fifteen years. I mean, I think…

GW Academically, of course.

JB Yes. Yes. And not only academically, they've been exceedingly nice people, and I think they are motivated too.

GW Yes. Being very good at 'A' levels doesn't mean you don't have compassion.

JB Oh no, not at all. I think they're a very compassionate lot. I mean, we sometimes have to tick them off for being untidy or late, but practically never for being rude or unkind to a patient.

GW Do you… you've examined in a good many other schools, haven't you.

JB Yes.

GW Would you say that you have noted major differences in this way, particularly in learning the art of physical diagnosis and history taking? Do you think it's deteriorated in the last fifteen, ten… fifteen years?

JB I think that's a difficult question to answer. Perhaps I could go back a long way. When I went to Cornell, the pat view of the American medical school was it was all science and no bedside teaching. This is absolute rubbish. I got a very fierce grounding in history taking and physical diagnosis in Cornell. In fact, I've had my histories torn up more than once, and told to do it over… you know, none of this nonsense about, 'That's not very good.' They really went for us. So I started in a pretty hard school. I think it's become more difficult to teach it well, recently, because

I think the numbers are bigger to start with. I think there are very many more people involved in many introductory courses than there used to be. There's nothing quite like having a group of five or six students and taking them right through. And if we had enough teachers who had enough time to do that, I think it would be splendid. But the difficulty is that… I think most of us have got much more busy than we used to be. I don't quite know why this is, but everything seems to have multiplied. You know, I remember when I could spend a whole afternoon dictating my outpatient letters to a secretary. Well, that's unbelievable now. You slap them on a tape at midnight, or early the next morning.

GW And be thankful if they're done.

JB Yes. I think that it has become more difficult because people don't have so much time. With regard to varying standards, yes, there is a difference. I mean, I think that some schools have a bigger tail than others. I don't think we had a very big tail in Oxford. If we had people who were really bad, there usually was some other reason why they were. I mean, either… well, disenchanted with medicine, or had some psychiatric problem, or one thing and another.

GW But that… I just wanted to bring out the fact that this has really been for you, a major interest in life, hasn't it… to teach and to… and, in a way, this will follow through when I come to talk to you about the College [Royal College of Physicians]? But, in regard to Oxford and the founding of the School, looking back, are there changes … would you have done things differently, your own role in it, if you were to do it again? Or do you feel that, in the circumstances, and with the financial restrictions and so on, it's been so exceptionally successful as it turned out? But are you critical at all of some of the developments?

JB Yes. I think… I think it's worth saying that we were very, very fortunate in having a good team of physicians and surgeons here, initially, and then, thanks to Lord Nuffield's munificence, we appointed five very good professors. So we started off with really high quality people. And I think that, you know, if anything, the quality of the professors has improved. I mean, I think we have an exceedingly good team now. All the major jobs seem to be filled by first class-people, and, of course, if you get that, you attract good young people. Another interest I've had down the years, of course, is planning and developing the new hospital [John Radcliffe Hospital]. Now, we made a crucial decision, I think by only a handful of votes, a long time ago now, to develop the Manor House site, and not develop the Churchill site. I'm not sure everyone suspected that was the right decision. It might have come off better than it has, if we had not suddenly found ourselves cut in half in the middle. I mean, the idea was that the John Radcliffe would be a 900-bedded hospital. We would close the old Radcliffe [Infirmary], or sell it to the University – it would make a splendid College or extension to the laboratories – and we would build a major acute hospital on the John Radcliffe site, and a subsidiary hospital, a slower stream hospital, would be on the Churchill site, where there's a lot of room to expand. But, about half way through the planning, the powers that be decided that about 450 beds was all we would get, and that just wasn't big enough to get the bigger pieces of the jigsaw into it. The trouble is that the pieces are quite big now. I mean, the accident, plastic surgery, or maxillofacial surgery bit is a very large bit. The neuro-sciences are a huge bit, and paediatrics and all its trimmings is another big bit. So something had to go. And what has happened now, of course, is

that we've got really, three acute hospitals, or two acute ones and one slightly less acute one, and that does make it difficult, I think. Oxford, although it's a small city, can be quite tricky to cross in the rush hour.

GW Oh, indeed!

JB And tired people think, 'Oh, it's just too much of a hassle to get the car and go to a lecture, and then go back again.' So I think that's a pity. I think, also, although I had a hand in planning the John Radcliffe, I think we made some mistakes in planning the John Radcliffe, but I don't think I need bore you with that now. But one of the results of those mistakes is it's quite difficult for people to meet each other.

GW Yes. Yes. I think everybody complains about that.

JB Yes. And I think the contrast…

GW With the old Radcliffe is…

JB Yes. I mean, down that main corridor, went the bread, the patients, the bodies, the lot! And everything met everything. But I think … it wasn't entirely a matter of design. When it was about to be opened, the then Chairman of the Board of the Area Health Authority, was a rather egalitarian person and didn't believe in such things as consultants' dining rooms. Well, it sounds a small matter, but, in fact, it's a very important matter, because there's nowhere where the staff could meet and have meals, so they began to have sandwiches in their own offices and get their secretaries to make them some coffee, and I think this was a pity.

GW This is an American idea, isn't it?

JB Yes. Yes.

GW And I often find it very hard that… because these accidental meetings over lunch, of consultants, can be so very valuable.

JB Yes. And also, not so accidental. I mean, if you knew you were going to meet a particular chap, you could save the conversation up until then. But I think, in any event, of course, we've got very big. I mean, that doesn't make it easy. It's hard… you know, when I was Chairman of Staff, I would look round the Staff Council sometimes, and say to our splendid secretary, 'Look, who's that?' And she'd say, 'Oh, it's a new anaesthetist,' you see. And even now, all my colleagues are difficult...

GW You mentioned earlier that, because of your experience in Oxford, they roped you in on the clinical developments in Cambridge.

JB Yes.

GW Now, there, they didn't have a Nuffield to help them out.

JB No.

GW And life was enormously more difficult in setting up that School, wasn't it.

JB Yes. I think it was, actually. Although, of course, by then things had got more formal. I mean, all the way along. When we, for example, when we started to plan the John Radcliffe, really, the Department of Health had very little guidance. UGC [University Grants Committee] had very little guidance. We got away with murder. But by the time we'd finished planning it, building regulations and everything had come in, and the UGC knew a thing or two about laboratory space per man. So Cambridge started rather later with those parameters restricting it a bit. I think, also, they had a lot of trouble with their pre-clinicians. They were very much – I don't know – focusing on this business of differential salaries. The importance of the prime salary and all that, and how do you…

GW And the early clinical appointments could only be made to people who were prepared to accept …

JB That's right. And, on the whole, I think you get what you pay for, don't you. But I think also, of course, it's… I mean, we, I think, suffer to some extent, from our catchment area, compared to a huge big metropolitan city. And I think that must be even more true in Cambridge. I don't know why it hasn't got going. We were very keen on it, and worked hard to make it a success, but once it was commissioned, we had nothing further to do with it. I mean, the planning team was disbanded the moment the thing started to be working. So I haven't had anything to do with it since then.

GW You've examined there, of course?

JB Oh yes. That's a very enjoyable experience in the summer time. I don't think there was much difference between Oxford and Cambridge. The only thing… I remember having arguments with the then regius professor…

GW Mitchell?

JB Mitchell,[4] yes… because they had a close marking system, and Mitchell was an extraordinarily, nice kindly man, and he'd say, 'It's only half a mark here.' But the rest of us used to say, 'Well, half a mark means a lot in this system.' And we weren't too keen to let him lift the lame dogs out over the stile. But he would always do it if he could. A very nice man.

GW Well, could we turn to the College, because this is a major part of your life, and has been for a long time. If I may rehearse a little, you got your membership in '49, you got… which must have been fairly soon after your military service and so on.

JB Mmm. It was.

GW Then you had your fellowship in '59. You were immediately a Goulstonian Lecturer, later a Lumleian [Lecturer].[5] You were a pro-censor, censor, senior censor,

[4] Joseph Stanley Mitchell (1909-1987) regius professor of physic, University of Cambridge, 1957-75.
[5] Sir John Badenoch was invited to give the Goulstonian Lecture in 1960, an honour restricted to one of the youngest newly-elected Fellows of the Royal College of Physicians. He was Lumleian Lecturer of the College in 1977.

and now Hans Sloane Fellow.[6] So a very major contribution to the life of the College. And I would be interested on two scores, really: one is the membership exam, and the changes that have occurred in that in recent years, and how you view those changes, and perhaps we could talk about that first, but then I would like to go on, very much, to your international responsibilities.

JB Yes. Well, I think, you know, these are, to some extent, are linked. The… I mean, the College did me a great me a great honour in making me Goulstonian Lecturer. And when these things happen, it fixes you to an institution, doesn't it, really. I think everybody feels that. It's nice to get recognition one way or another. But I think, I suppose, I got appointed as an ordinary membership examiner, and I had had a fair amount of experience examining in other places, and I always rather enjoyed doing it. And then, I think, really, my two College interests began to combine, because I'd always been interested in overseas matters, and in particular, I felt quite strongly that Britain still has a lot to contribute to people overseas. And interestingly, I've, as you know, recently had the privilege of talking (a) to Princess Anne, and (b) to the Queen. And on both occasions, we've talked about this, and both of them said, rather surprisingly, 'Do people still want to come?' And I said, 'Yes, ma'am, they're falling over each other to come.' But I'm saddened, in a way, that this is a rather general view that Britain, perhaps, has lost its place in the world, and perhaps hasn't got so much to contribute. And I'm saddened, of course, also – and we'll keep politics out of this – but I think one of the disastrous things the present government has done, is making it so difficult for foreign students to come here. But we can come back to that. But coming back to the membership. I think, really, what happened was that it was the Leeds Castle Conferences that really stimulated me, I think, where the College was really saying to overseas friends, 'Look, what can we do to help? We don't believe that a College… that exporting our type of examination to Sri Lanka, or the Sudan, or what have you is, right. What we would much prefer to do is to help you develop your own.' And I think, in large measure, that's exactly what the College has done. And, of course, the family of nations is still very variable. I mean, there's no point in saying that, at the moment, in Nepal. What Nepal needs is an opportunity to get their best young men to come here for the simplest form of general medical training and leading to the MRCP. That's all they aspire to at the moment. Others, like… like Singapore and Sri Lanka, have already got examinations in every way comparable to the MRCP. In fact, I think the Sri Lankan one is more difficult. And they now want us to do something quite different. They want us to take their good young men who have already got the MD, and train them in specific fields. And I think, really, the two Leeds Castle Conferences led on naturally to what I'm trying to do now. What pleased me so much about the Hans Sloane Fellowship was that it gave me an opportunity to do something for the College. I've always been interested in the College, and to be given an office that really has a proper job to do, is very, very pleasing and also one that I wanted to do and enjoy doing. And I must say, it's in its infancy yet, but people are awfully good. I think they're very fond of our College. And, for example, just take two groups of people, neither of whom are in my own specialty: the cardiologists and the chest physicians, both couldn't have been more helpful. You know, if you say… I, from time to time, get good young men and women, and need to place them in the equivalent of registrar or SR [senior registrar] posts in this country, they go out of their

[6] Sir John Badenoch held the following offices at the Royal College of Physicians: pro-censor and censor, 1972-73; senior censor and senior vice-president, 1975-76; Hans Sloane Fellow, 1985-91, responsible for arranging hospital training for overseas doctors.

way to be as helpful as they can. And others have been equally good, but I just mention these two specially. The problem, of course, as always, is money. And sometimes I feel that the parts of the world we'd like to help most are the ones that we're least able to help because of this cash. I mean, there are any number of people we could take from the Middle East without any problem at all. I hope we'll go on helping Hong Kong and Singapore, although they don't need money. But they are rather special, and have gone a long way down the road. But I would dearly like to be able to do more for India and Bangladesh and Pakistan and the emergent African countries.

GW Princess Anne, whom you mentioned a moment ago, when she made her splendid speech at the College recently, she did draw attention to… when she was going around the more remote corners of the world for Save the Children, that the people were, of course, operating there without the modern equipment, or the technological aids, or, indeed, even the simplest technological aids to practice. And were we providing the best model, shall we say, by asking them to take our membership. And you've just mentioned that, of course, that it's just the more remote parts of the world that it's so difficult for us to help.

JB Yes.

GW But should we help them, do you think, in any special way? What I'm trying to say, really, is can one, perhaps, combine a knowledge of all of the technological advances used in diagnosis and treatment, but, at the same time, keep the grounding in, so that they're not dismayed when they have to manage without many of them.

JB Well, it's a problem, isn't it?

GW Mmm.

JB I think you can approach this problem from several angles. I think the first point is that if you take the developed nations as a group, Britain is probably the best nation to do this. We have got used to doing things on a shoestring in this country. I mean, I know we practice high tech medicine, but, in fact, we're always looking over our shoulders – have been for years, let alone the present cuts – on what we can afford to do. And, whereas if a young man or a woman from, say, Bangladesh, goes to Canada or the States, or West Germany, they do get a very plushy view of medicine. I think we… although we do practice high tech medicine, they would learn, certainly, they had to watch the pennies. I think it's difficult. After all, we are a specialist community, we profess to be interested in the higher flights of medicine, in its broadest sense. We're not really in the business of teaching people the basics of primary care, other people can do that. And, of course, many of these countries need that more than anything. I mean, they need family planning and basic nutrition and these things. But even so, even in the backwoods, or underdeveloped country, there must be some people who are leaders of the profession, there have to be. And I think we could pick those up, and teach them, perhaps not cardiac transplants – that would be stupid – but, I mean, good, solid general medicine. And also, of course, teach them the British attitude to it, which, I think, is something that we tend to play down, but is so important.

GW Do you think that apart from their people coming over here, their best people, to do a higher degree or whatever – I don't mean only to study for the membership, but after that, having taken it in Sri Lanka or wherever – would you envisage that in the future, through your office, that these people would be able to come back for sabbaticals, or refresher courses? I mean, at least to give them the mental and intellectual stimulation that they would lack.

JB Yes. I think this would be terribly important, actually. I mean, I think that if you could bring them back once every five years or so, or whatever suited their plans, it would be helpful. And, of course, again, it would cement them on to the UK, which is what I would like to do. I think there is another side of this coin, of course, and that is finding teachers to go out there – this isn't so easy. And it's quite interesting to analyse why it isn't. I think, firstly, most people who are holding down a job of worth in this country, are rather important and indispensable – can't just up sticks and go. The lucky ones, who head a professorial department, are a little bit more free because they have experienced senior assistants. But many people working for the Health Service don't, and they have a… their senior registrar is doing another job, equally important – they can't double for the chief entirely. And so it's quite difficult to get people to go. And I have hopes that the ideas we had of persuading regions to appoint consultants pro-electivally, say a year or eighteen months before they're going to take up their duties, so that they would then be free to travel without the worry of… worrying about their future, I think that would be a very good idea.

GW That would be a splendid idea.

JB But there's another aspect of this. You know, this constant business of, is it right to teach these people high tech medicine? I mean, is that not, in fact, a misuse of resources. Well, *in extremis*, it would be. But when we had a recent lecture in the College by Evans, who works for the Royal Charter... - John Evans, who used to work, actually, in Oxford with me - and he said the Royal Bank have a very interesting approach. They do quite a lot of this, they bring people over for training. But John told me that when he gets an applicant, he asks the applicant not only for his own curriculum vitae, but for the curriculum vitae of his country, medically speaking. And then when the applicant comes for interview, he says, 'Look, how do you see the training you're going to get, fitting into the needs of your country?' And I think that's a very salutary way of looking at it. And I've started to do that now with the people that I'm trying to help. 'Okay, you want to be a cardiologist. What are you going to do with it when you go back? Are you needed as a cardiologist?' And I think enough of that just sets them thinking a little bit.

GW I'm sure that the… no matter how remote or backward the country, that they must have some people who are at the forefront of medicine.

JB I think so. I think so.

GW It doesn't necessarily follow that the other people are not as valuable to the country. I mean, it isn't a sort of elite in that sense, is it?

JB No. No, no. But it's an intelligent vanguard, really, I suppose, isn't it. And I think it is quite true that most of these countries desperately need something that our

College doesn't particularly offer, in the way of basic primary medical care and nutrition and so forth. But somebody has to organise it, rather further up the…

GW And, of course, these people must have someone to whom they can refer for a second opinion of real value.

JB Yes.

GW Even if they haven't got all the technological aids.

JB But I think, you see, I mean, I've had a grievance too, with some of the Medical Schools in the Middle East. I think there's going to be a good one in Oman, in (Al Khod?) near Muscat. And I was a member of the original planning group that looked at that, although I haven't had much hand in it since. And I've since kept in touch with them. And, of course, they have staff from all over the world. I think the dean is a Canadian, and they have staff trained in British medicine, in German medicine, in other parts of Europe, even a few from the Iron Curtain countries. Now, it isn't only a matter of medicine, it's the attitude to medicine, and I think it must be very difficult. I… and feelers were put out some time ago for me to go and be dean in one of these medical schools, but I didn't take it because I don't think either my wife nor I would like to live permanently in the Middle East. But I think one of the difficulties would have been trying to get all these people to work together, from the point of view of their attitudes, rather than their skills. Skills are no problem really. But it's the way you look at your work, the way you look at the patients, and I think… I think the British way is a very good way, and I would like to see more and more developing countries pick up that and develop it.

GW Well, I feel it necessary to ask you, nevertheless, a rather uncomfortable question in a sense: you were talking about bringing the regions into the contribution to this, and so on; do you feel that a fair number of our people are not really sharing this sort of British view of responsibility in medicine? I mean, I'm sorry to say it, but you do meet them, who are in it for the money, or they're in it for power, or promotion, or social prestige.

JB You mean in medicine, or…?

GW Yes, I mean in medicine.

JB Yes. Yes, I think so. Of course, now that you and I are both a bit senior, we have to guard against saying that, you know, life was better in former times. But I have seen a rather sad change, I think, in the attitude of our profession. I mean, I'm not talking about overseas matters now, but home matters. I think it's a compound of many things. But, you see, I was brought up in a household with a single-handed general practitioner, who worked pretty well twenty-four hours a day, and ate and slept when he could. And some of that rubbed off, I think. Now, obviously, that was a silly way of behaving. I mean, it could be dangerous. Indeed, I remember it being dangerous, when I was a houseman, and doing some awful things that I wouldn't like to do now. But I think it's been very hard to maintain that sense of service and commitment, in the face of modern organisation, and umts [units of medical time] and off duty and rotas, and all this kind of thing. There seem to be two parallel threads running in medicine

now. One is a very caring one and the other is one which is much more mechanistic. I don't think that being a high-tech cardiologist need destroy your ability to be a good physician at all, but it's more difficult to be one. And if you have a group of people who are technically minded, working for you, it's very difficult to make sure your patients get a really good physicianly approach. I think it was easier, even… and I'm thinking back now to Sir George Pickering. I mean, his research was personal research. He did it himself, man to man, patient to him. Now, most research is done in teams. And unless you pay a great deal of attention to the organisation of your team, I think patients can very much feel that they're just bits in the machine, and not important people. I think it's difficult. I don't quite know how we overcome it. I think… just recently we had a day at the GMC [General Medical Council] on communication with patients. And, of course, as you know, Charles Fletcher has always been keen on this. But he has a point. I think the very modern tendency to go for alternative therapies, holistic medicine and all of this, is symptomatic of this.

GW Yes.

JB I think it's our own fault. I always used to think that it took an hour, really, to find out what was bugging a patient – by that time you're getting the third history, which is important to us. And you can't do it in five or ten minutes, and you certainly can't do it if the notes are that thick, and you've never seen the patient before. And I think we've got to put our house in order on this.

GW But you said, 'within this country'. But I feel that this possibility of, at least, providing some service overseas, is one way in which some people, anyway, would recover that spirit.

JB Yes. I think so. But I'm a bit sad about this too, actually, because I recall when I was an undergraduate here in Oxford, quite a high proportion of my undergraduate friends were determined to do this. They were going out to be administrators in West Africa or join the Indian Civil [Service] or something, and quite a high proportion of them were going to take on very tough jobs for not much pay in remote parts of the world. And I don't find that feeling now, at all. In fact, when I have talked to the press about the Hans Sloane Fellowship and the overseas office, I get a pretty rough ride on the whole. And people say, 'Why should we bring all these black men here?' you know. 'We have enough problems of our own.' There isn't a kind of global view anymore, which is sad.

GW No. This is what is, to me, very sad.

JB Me too. Maybe we can redevelop it.

GW Well, I'm hoping that this office of yours is a step in that direction.

JB Yes. Well, it is a step, but only a step.

GW Of course, one of the things that we could do to help – I'm sure your office will – is that it has been made, in the last thirty years perhaps, really quite a disadvantage to have served abroad, and to have… I mean, whatever the experience – which can be, of

course, fantastic in it's quantity of disease and variety of disease – we've really rather tended to punish people for…

JB Well, we have. I think the College, not only my office, but our whole College could help with this, through its members on appointing committees and so on. And the young, of course, feel this. Registrars, senior registrars, they are unwilling to step out of line. The competition has been so fierce. But perhaps if we get our manpower numbers more sensibly arranged, things would be better. But, you see, I often wonder, nationally speaking, whether one of our problems isn't, we're still trying to be a great power. And maybe if we stopped trying to be a great power in the military sense, we could then be a very great power in the intellectual and professional sense, because I'm quite sure that we have a great deal to offer. And, after all, more than half the world is anglophone. They start with an enormous advantage, they speak English. And if this poor chap goes to Bulgaria, or even Germany, to learn medicine, he's probably got to start from scratch by learning one or other languages.

GW It's astonishing that they do it at all.

JB It's amazing, and they do it. But it can't help their medical studies. And I would hope that we would do more and more of this. And that's why I was terribly pleased, recently, at the GMC, when an application from a Chinese medical school was approved, and there have been no Chinese medical schools approved for…

GW For recognition, for limited registration…

JB …since 1953, I believe. But the first one has come through and has been approved, and we're expecting a rush. And this will mean, I think, that many of the old links we had with China, which were considerable, will be rebuilt. And that's fine.

GW I'm sure that's to a very great mutual advantage.

JB Oh yes, I'm sure.

GW Well, it's an exciting prospect, and you almost require a new youth.

JB Well, I've got five retirement jobs! And I don't feel retired at all. I think… a few years to get it started. I've tended to do that in life, start things and move on, and then somebody younger and more vigorous could take it over, and see how it goes.

GW I doubt if they would be more vigorous.

JB I'm not sure.

GW But John, I think that… I'm very grateful to you. I think it's important that we should have this on the record, and the College can only be grateful to you for your explanations today, and also, of course, every one of us wishes you well. And I hope the Fellowship will be ever more supportive to you in these efforts.

JB Well, I think there's a great deal of goodwill for the College, and I find that if I just have to say 'from the College of Physicians', things happen.

GW Of course, it is a remarkable network, the Fellowship itself. And one can only hope it becomes more so.

JB Yes. Yes. Well, I think our present President has done a lot towards that, don't you?

GW Oh yes. Well, thank you very much indeed. I think we'll end it there.