Interviewee: Lord Robert Kilpatrick of Kincraig
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MM: Sir Robert Kilpatrick, Lord Kilpatrick of Kincraig, graduated from Edinburgh University in 1949. At the height of his career he was professor of medicine and dean of the faculty of medicine at Leicester University and President of the General Medical Council. Later he was also President of the British Medical Association. He held honorary doctorates of five universities and was a Fellow of the Royal Society of Edinburgh. He was made CBE in 1979 and was knighted in 1986. He became a life peer in 1996.

MM: Lord Kilpatrick. You were born in 1926 in Fife.

RK: Yes.

MM: Could you tell us a little bit about your background at that time.

RK: Yes. Well, I was an only child which was unusual at that time. I had a forceps delivery and I suspect that that was obviously a very difficult birth and I suspect that was the reason no others were – came along as siblings. And I went to school… I should explain. My father was a miner, coal miner, so it was very much social class [five]. Went to school in the village, Coaltown of Wemyss. I was a… I was small and slight until I was about 16. That remained throughout primary school and secondary school. I was always small and slight.

MM: Could I ask you a little bit more about that time because I think the year 1926 is quite significant, isn't it?

RK: Oh yes. See, I was born… the National General Strike had taken place a few weeks before but I was born during the continuing miner's strike which went on I think until… September, October? Maurice Shaw, who later became a very close friend of mine, was also born in 1926 said it's a very special vintage because of that.

MM: That was one thing I would like to ask you about because that must really have been a significant event that affected you possibly for the rest of your life, in some ways.

RK: Well, of course I've no memory of 1926. But I certainly have clear recollections of deprivation right until mid-30s I would think, when I would be… Well, I left primary school in 1938 and it would be – I mean, I can remember my father, who worked very hard, did a lot of overtime etc. but he was bringing home somewhere around two pounds ten shillings a week. I wasn't as deprived, now this was very obvious to me at school, as those – my colleagues who were from large families. Some of them were extremely… They were in… One of them didn't have shoes. I can remember that.

MM: In a certain way, adequate survival must have depended on the skill of management at home.

RK: Yes. I was also… I had personal problems in that I had allergy. Quite severe allergy. I had infantile eczema and I've had periods of eczema ever since. Now, really very slight over the last decade but significant. And then I began with asthma. I don't really remember when but it must have been before I went to school. Probably after four. And because of that I was always mollycoddled by my mother. I was much closer to my mother than my father. Well, I saw much more of her, obviously. And she… You can understand why she did but in fact it was the very opposite of what should have been done. I can remember for instance going to school in the winter with cotton wool around my chest and being given Virol. You know, it was malt with cod liver oil. All sorts of supplements really when I think back to it. Ovaltine at night. But I had problems and then I had a severe illness. I had diphtheria at the age of seven and that I do remember very well. Being extremely unwell, sitting beside a fire and then blacking out. And I was taken to the local infectious disease hospital which was in Thornton. And I was – I have no memory for about three days. I was treated with antiserum, which must have been a very brave decision by the general practitioner, a chap called Skinner who was a very striking GP whom I have recollections about much later because of my allergy. But I woke up three days later in this hospital and it's a very vivid memory. Waking up in a ward with about two or three other people and then coming home a week or so later. I must have been near death I would think. But that cleared and I remained with – I was always chesty because of the asthma. Always liable to get upper respiratory infection with a cold and continued to be mollycoddled. Then I went to… I was a lad o' parts. Pairts. And was top boy in that primary school and I then went, with a resounding shock, to secondary school which was in Buckhaven three miles away. As I said, I was small and slight and I was perpetually bullied throughout the whole time. Well no, not the whole time. Not after I was 16, 15 perhaps. Mainly verbally bullied, some physical. And I think that my major memory of that is in fact that the boys who bullied me were really apprentices to the teachers because it was the teachers who bullied. It was really very striking. There was one I remember called Anderson who – he was called Bulldog. That was his nickname. He was a mathematics teacher but he would stand halfway up the stairs going up to the first floor, on a landing. And if someone strayed in any way passing him as you were going in he would hit them over the face or head. Hard. There were others as well. I can remember a French teacher, fairly young, tall, well-built. And he used to apply the tawse not just to boys but to girls as well and always, far as I can remember, because they got some part of the teaching wrong! It wasn't behaviour it was just simply that they… and thinking back it had an enormous effect on me in relationship to how I then behaved and taught later.

MM: Did this give you – were you in that way isolated at school or were there a group of - ?

RK: Yes, yes. I was an outsider. I didn't take part in sport much. The sport I took up, which I did take up early on at about 12, 13, was golf and I became later quite good at golf. I had a handicap of… well, I can tell you a story about that at a later date – at a later time. But I didn't take part in team. I did a bit of cricket outside of school, extramurally, but virtually nothing in the school.

MM: At school when you were there, was there anything like streaming as it were?

RK: Yes.

MM: Where a body of people go –

RK: Oh yes. Immediately. Immediately I went. It wasn't streamed in relationship to… Up until my year, you got in to secondary school of two different kinds. One was like Buckhaven, was an equivalent of a grammar school, and the others were more like what became comprehensive. So you had to sit an examination called the control examination but that was discarded just the year before I came up to it. And it must have been done on some kind of IQ, testing though I'm not aware of having the test, but I must have done because I can remember the headmaster taking a group of us and saying, "Four of you can go to Buckhaven without there being a control exam. That's been given up." So there was some streaming for everyone who went then to Buckhaven. The streaming that was then done was in relationship to subject. If I have an overall view of my 70-odd years, it's that I've been under a fortunate star to a considerable degree because one stream took Latin and I chose that without really having any very good idea why I should. I think perhaps it was because I was interested. But it became later of great significance in trying to get in to medicine. Because you had to have, at the time I went in to medicine here in Edinburgh, 1944, you had to have Latin in your school certificate. The other three – you divided into four classes for the year and the others… I can't remember the details, but it was in relationship to subjects.

Though I was an outsider I was very influenced by, and I think this applies to so many people who have done anything significant in life, I was very influenced by individual teachers. Two in particular in my early years there. One was a woman called – who came from the adjoining village, and she taught English and she was an enthusiast and communicated it to those who were receptive and in fact I considered very seriously reading English literature when I came up to university time, but finally didn't. The other was a history teacher called Hood. I can remember them because they had such an effect. And the other whom I encountered much later, by the time I was 17 and I had sat Highers by this time and I had taken Latin. There were lots of reasons why I chose to go into medicine but it was made clear to me – this was now '43, the war was clearly on the way to winning – and selection for medical school was becoming fierce. This was made clear to me at school. And a teacher whom I'd only just really come across because she'd come recently, a woman who taught mathematics, she said, "I think you should sit the bursary competition of the University of Edinburgh." Because I had made up my mind that I would come to Edinburgh rather than as most people did at that school go to St Andrews. So, I got the particulars. It's a very interesting little vignette really because the bursary competition at that time - it's long since disappeared - you had to sit three subjects or, if you didn't by choice want to do that, you could sit two subjects but one of them had to be doubled. And doubled meant, and they made that very plain, up to first year university standard. That seemed pretty difficult. Science at this school was not well done. It was not split. It was done as a combination of chemistry, physics, with no biology whatsoever. I came to university with no biology core teaching at all. And the chemistry was entirely inorganic and so it was very clear that I couldn't sit either chemistry or physics, and certainly not biology. So what I did with her encouragement is I did English and mathematics. I had done Higher mathematics. But it was not – I mean I've met many, many mathematicians since and they are gifted people in mathematics, inevitably. And I was not that, but this seemed the only route and she said she would give me special coaching. Well, the upshot was at not quite 18 I sat the bursary competition. They gave 50 places and I got one of those places but no scholarship. I wasn't high enough up. But I got entry. Now, two others in my year applied for medicine but didn't get in and I'm sure that that was the crucial point was that bursary competition.

MM: Could we go back a little bit. I mean by that time clearly you were aiming towards higher education certainly.

RK: Oh yes.

MM: Now, do you remember which was it? Was there simply an assumption you were going on to higher education…

RK: No, it wasn't that at all. I was in a family which in many ways was very similar to the great bulk of families in the village where higher education would never be thought of. Never considered. And all that my mother wanted me to do was to make sure that I could get a job that was not the coal mines because she said, "You'll not be able for hard, physical labour." But it was never discussed. However, I had an uncle who was another feature of the fortunate star. He had emigrated in 1910. Having been in the coal mines for two years he didn't like it and he went to Canada, he went to Alberta. And at that time you were given large tracts of land in Canada provided you were willing to be frontier land, break down the trees and so on, and turn it in to an arable stretch. Very hard work. But when I met him – and it was much later that I met him, in fact I met him when he'd come back. He came back in 1928, so he'd done 18 years in Canada. And he came back to ensure his two sons, who'd been educated in Canada, would go to university here and they went to the University of St Andrews. One did medicine and one did divinity. The usual thing, you're either a doctor or a minister. And it was my meeting him and listening to him because he was a most entrancing man, marvellous outgoing personality. And he kept saying to me, "What do you want to do a job for? You want to go on just like my two boys. If they can do it, you can do it." And it was after several encounters with him that I thought*, Perhaps that's what I should do*. And I chose medicine very simply on the basis that one, his son had done it, and two, he made it clear that it was a profession that gave you fulfilment but also gave you a lot of money, a very important factor in a life such as I had had.

MM: It's one of the common Scottish motives, isn't it? I mean, there's that book of Kenneth Collins *Go and Learn* that it's the way up, medicine is.

RK: You move class.

MM: Yes. And you see that it was that uncle that was the main influence but one wonders if other things were in the background. I mean, that deprivation that surrounded you.

RK: I'm sure that was a factor. Yes, I quite agree.

MM: And your own experience of illness.

RK: That I would ensure that I would get out of that.

MM: Yes. And the relation to your own illness and diphtheria.

RK: And that as well. Yes. And a continuing saga of course with asthma. I mean asthma was the reason that years later when I had a medical for the armed services that I was turned down.

MM: You mentioned when you went from your primary school to secondary school that that was something of a shock. What about the shock of moving from your school to the university?

RK: To university? Well, it was a shock in many ways but it was also… pleasurable by and large because I had disliked school. I had disliked one being treated as part of a mass of children and teenagers whereas when you went to university you were left to your own devices. You got on with it. It was up to you. And that I certainly then responded to. It was part of the reason why so much

later when I was at the General Medical Council doing Tomorrow's Doctors that I think it's a cardinal feature of a good education is that much of it is a self-education. Provide the environment and they'll respond.

MM: When you came to Edinburgh, how did you live? Were you in digs or…?

RK: I was in lodgings, yes. We nearly all were. There was only one hall of residence here and that was… you had to be from distant parts. It was cosmopolitan, entry in to Edinburgh, as it had been for a long time. There were 200 in the year. An extra 50 because of ex-servicemen coming back. They were already coming back in 1944. So I was in lodgings and in the same lodgings was an individual in the same year just entering as myself, he was a state scholar from Yorkshire, [Redgirn] in Yorkshire and a girl and they both became – and they married in fact each other and became very close friends of mine and still are. And she had been in Canada as an evacuee and had already done one year of medicine – two years of medicine at the guild. Then she came back and she entered into second year at Edinburgh. So here were two of us first year entry and her as second year. It was a great pleasure to meet them and to be drawn out because I think I was very raw. And I had… Another feature which I think to a degree I still have, I had low self-esteem and not much confidence.

MM: I was interested. Edinburgh struck you as cosmopolitan.

RK: Yes.

MM: And some people have. But one or two other people interviewed have remarked on the strangeness of coming where there was a very large block, for example, of Watsonians

RK: Oh yes. That was also – it wasn't very obvious to begin with because it was such a large year. But it became more and more evident over the five years. It's a feature of Edinburgh life and I think it's still to a degree a feature today. It's not as evident as it was. If I tell you that encapsulated in an interview I had. This was now in final year by which time I'd become, as would be said, I'd done well. I'd had distinction in second professional examination and I'd had an encounter with Derrick Dunlop over a clinical session which obviously impressed him etc. Anyway, I was asked to go for interview for a house physician job with the professor of medicine, Stanley Davidson. In fact, Stanley Davidson was in Australia on a Sims travelling professorial fellowship. So I was interviewed by his first assistant, an individual called Hamilton, who I later found out was a major figure in the Scottish BMA [British Medical Association] etc. He interviewed me in the corridor of the Royal Infirmary, not in a room, just standing at a window. And he only asked me three questions. What was the occupation of my father? Which school had I been to? And did I play rugby? And he was a… not a leader in the profession but he was a feature of the elitism which was in Edinburgh all the time at that time.

MM: That is one of the [features]. There were obviously some of your teachers at school that impressed you. What about your teachers in medicine if we could go back to the pre… Was there anybody in preclinical, for example?

RK: Oh yes. It depends on how you define impression. People that I remember… The most striking one preclinically was [Edward Bald] Jamieson, the anatomist, who had retired but was brought back because the professor called [James Couper] Brash was ill in our first year. Jamieson was quite an extraordinary figure. He had been married, I later found out, but he was very obviously a fervent misogynist. The dissecting room, an enormous room, was in three columns of tables and all the women, there were about 50 of them out of our year, about a quarter of the year were women, were on one column and the other two columns were males. Jamieson would come in to demonstrate, and for that matter to take oral examinations. He never, ever went to the female tables. Not ever. He'd just walk to a table, sit down, because there were a large number to each

table. It must've been of the order of eight. And he'd demonstrate a section of whichever part we were at at that time. He had a – he wore a little skullcap and he had a sort of skeletal look. He was very thin. Cadaverous really, thinking back, and he had a deep, resonating voice. Often, he would say as he was getting up to leave, "Come with me, boy." And he would take some 18, 19 year-old fresh complexioned, pretty chap down to his room where he would then tell him in succinct detail, saying to him, "It's very important that I tell you this", about the dangers of venereal disease in the female with graphic descriptions and plates. I won't enlarge on it any further, I think. But it was a very striking experience.

MM: That's interesting. One or two other people have mentioned finding him intimidating.

RK: Oh, very much so. And dominating, too. Well I got a prize in anatomy. He had never met me, he never came to our table, but he wrote to me while I was in third year, first clinical year, saying that he had just found out that I had had this prize and he hadn't met me and would I come and have dinner with him in the Bruntsfield Hotel where he had a permanent residence. He had a house in the Shetland Islands. He also had a brother, a professor of anatomy in Northern Ireland, I later found out. Not knowing what to do I just went along and the dinner, he made it himself in his room over a little sort of gas stove. He gave me soup and fish, I think. Talked a bit about my background. Very little of his own. And then I said I had enjoyed his dinner, thank you very much, very nice to meet you because I was becoming a bit more confident by this time. I wouldn't have been able to have done that when I came. And got up to go and he came to the door and said, "Would you kiss me?" And I said, "No, I wouldn't." And I left. That was one.

The other was in fact the person he was standing in for, Brash. Not because I was so struck by him as a teacher or professor or whatever. I was struck by when I arrived in Edinburgh we were given a book list and in anatomy it gave several books, two or three of which I bought, but it mentioned *Cunningham's Textbook of Anatomy* which I found in the bookshop was enormous, two thousand pages! And I can remember, though I suppose it's partly being an outsider, I thought, *That's just stupid. There's no one can expect anyone to have read that!* Two years later I was asked along with several others to have - the second M.B. exam had finished - I was asked to go for a special viva in anatomy for distinction. And I went in… I'm just portraying it as it was in those days, nobody introduced themselves. There was an external examiner, I'd never seen him before. Didn't know what he was there to do! There was Brash and he took me to various parts, "What's this, what's that?" And then after about ten minutes he put up a chest x-ray. And he said, "Do you see anything unusual?" So I looked at it and I said, "Yes, it's got a little line from the apex of the right lung for about an inch and it ends in a little blob." So he turned to the external examiner and he said, "I told you one of them would get it." So I thought, *Great*. I almost turned to go away! And he said, "Good, Kilpatrick. Tell my colleague what it is." And I said, "I have no idea. I've never seen such a thing. It could be… is it perhaps a sequel of tuberculosis?" Which in fact it might have been. And he said, "Come on, Kilpatrick. This is an anatomy exam." I said, "I'm sorry, I do not know." And he said, "Well, I am terribly surprised. It's in the big Cunningham." And I went later and delved through this book and there was several pages of plates of x-rays and there this one was, and that appearance is due to an aberrant vena azygos causing an azygos lobe. And the lesson I learned, and I've continued it throughout my time because I was much involved in teaching is that there's a very real Pygmalion phenomenon. It doesn't matter which discipline you're in, if the individual is themself an anatomist or a physiologist or an ear, nose and throat consultant, they would like, with their pupils, or their apprentices or their protégés, they would like to make them the same as themselves. It's the Pygmalion principle.

MM: And who was the co-examiner?

RK: I never found out. Well, that was the preclinical. There were several people – Mary Pickford in physiology, I was very impressed with her. Anthony Ritchie who later became Executive of the Carnegie Trust, I also thought he was a very striking teacher. In the clinical…

MM: Before we – did you really feel… what was your overall feeling about preclinical teaching and the emphasis on anatomy and so on? Had it been a sort of bind?

RK: I don't know that I was that self-enquiring at that time, I think I just – I was a conformist and this is how it was produced and you followed it. I later had great questioning about the whole procedure. I think we had something like eight or nine hundred hours of anatomy teaching. And I later became a great sceptic, as George Pickering once said, "You can treat medical students in two ways. You can treat them as if they are pitchers into which you pour water until the water overflows, or…" and he gave an example of self-education. But I didn't at the time. I just accepted that this was - what I was struck by was the frequency of examinations in anatomy. You had a viva, an oral viva, every three or four weeks. I can remember I later became his house surgeon, an individual called Geoffrey who was quite well known, particularly well known for his private surgery in Edinburgh. He gave me the – I went to him and asked him to be the examiner for head and neck, which was the last part. And he sat down beside the part and he said, "Tell me the relations of the sterna mastoid muscle." And I said, "Alright. I'll do it from superior to inferior." And I probably spoke, because there are a very large number of relations underneath that muscle. And at the end of it he said, "I've never heard anyone do that before." He said, "How often have you read that?" So, I said, "Twice?" He was the first one I think who really communicated to me that I had this benefit of a really rather remarkable memory. But I was still a conformist. I just accepted.

MM: And when you moved on to the clinical years, did you have much scope for deciding who you were going to go to, which clinics and so on?

RK: No, we didn't. We were really not allowed choice. We were assigned. And I went to my very first clinical, a very striking experience, was with a physician called Smart who was a very courteous gentleman. Very gentlemanly features, behaviour, courtesy etc. And he took - the clinics were large. There were probably 15 of us in a clinic. And he took – he said to us, "I'm going to show you, because you've had a lot of physiology, you should be able to work out from what I'm going to show you what the mechanism is because all of these patients have oedema." And he took us, he showed us an individual with heart failure and then I think the next one was renal, acute nephritis. Because I can remember he asked one colleague, a male. He talked about renal oedema. He then took us to another individual who had unilateral oedema of one leg. And he said, "What do you think could be the cause of this?" And he looked at this chap and this chap said, "Renal." He says, "Really? How would you think that could be? It's only on one side." He says, "Oh, one kidney." [Laughs] I remember that very vividly. But the final, and he must have done this very deliberately, the final patient he took us to had a cradle over her legs, a large fat lady whom I can remember now, I can see her. And he said, "This lady has oedema of both legs which is due to her varicose veins and the pressure inside them. But she's had it so long and it has been so severe that the skin has in fact ulcerated." And at that he just nodded to the ward sister who whipped this cradle away and there was the most frightful sight I think looking back that I had ever seen, up till then. She had granulating ulcers almost from ankle to knee over her shins and about half a dozen of the clinic fainted, including me. And I had for several weeks a great worry that I was not going to be able to cope because this had been such a disturbing experience, to pass out. But it was done I think probably deliberately, just to show that you have to get used to these kind of sights. And I did. But it was a worrying time that first six weeks in clinical work.

MM: And who were the other people then who impressed you or that you met at that time?

RK: Well, there were not all that many. Derrick Dunlop. He was well known because he was a theatrical character and he was always on a stage. He was very affected theatrically. And I did, I think I mentioned, I encountered him in a clinic. It was my final year in a general medicine clinic and he plucked me out because I tended to stand at the back. I always did and still do, actually. And he plucked me out and he said, "I want you to feel his pulse." So I felt this pulse and I had felt enough pulses to realise there was something quite unusual because what it was is it was regular but every alternate beat was weaker than the previous. So he says, "Do you notice anything?" And I said yes and I described it. He said, "Do you know if it has a name?" So I said, "It's pulsus alternans." So he picked it up and he felt it. And it was so obvious thinking back from his body language that he didn't know this was so and for that matter he didn't think his staff knew. And then he then said to me – he gave me an ophthalmoscope and he said, "Could you look at his fundus." So I looked at the fundus and I wasn't very experienced in funduscopy at that time but I'd done it a few times. And I said, "I think he has early papilledema." And he said, "Do you?" He said, "This man has hypertension. What significance does that have?" And I said, "Well, it's given a descriptive" – I remember doing this because I was very conscious that patients listened – "It's given a descriptive word which means it's rather severe." And he just came out with it. He said, "You mean malignant?" And I thought, *That's dreadful*. But still, he impressed me. I met him several times after that. I met him in the main chamber through there when we examined in the membership. He was… Stanley Davidson was also memorable. But I think perhaps the major thing I realise is it was not – I was not getting adept because I wasn't being encouraged to become really good at clinical work. It was very didactic.

MM: Looking back, and I hope this isn't an unfair question, but looking back what do you think of the overall standard of the medical practice in the Royal Infirmary at that time?

RK: I think it's difficult to say what the actual standard was. What I was very struck by was that patients were hardly regarded as human beings. There were two particular things happened in the term that I did specials. That was a combination of ear, nose and throat, dermatology and ophthalmology all in one term. Right at the beginning of the term - it was winter - I got a respiratory infection and it became much more severe than any I had had previously. I think looking back I probably had marginally bronchopneumonia. I had to be off, back at home in Fife, because I was so unwell, for six weeks out of the ten week term. I had a bad time and I was given sulphonamide, because this was in final year, '49. At the end of the term they gave a prize in each of these three subjects and I got all three prizes. And I can remember saying to myself, *There's something wrong with this system.* I can remember the ophthalmologist who handed the prize over to me saying, "I don't know where you got all that knowledge but you certainly didn't get it from us." But the other striking thing of the same term of the four weeks that I was there was to see how dermatology was practiced. The professor was called Percival, he sat on a chair rather like this and patients were brought in one after the other and sat in the chair opposite him and showed, depending on where the skin lesions were, showed them to him. He never touched them and he didn't address any words to them. He said, "It's psoriasis", "It's lichen planus", "It's… " And then he would turn round and say, "Number 43." Which was the therapeutic prescription, which might be Castellani's paint or… I can't remember them all now, somebody's ointment – Whitfield's ointment! Etc. And I thought, *That's dreadful*.

MM: Well what about the surgical side of that?

RK: The one who impressed me particularly. Two. One because he was impressive, was Walter Mercer who became professor for orthopaedic surgery and in fact he gave a prize which I got and it

was an unusual prize, it was a biography of Harvey Cushing, which I later read. He was really very striking. The other who was impressive because he was so objectionable was [James Rögnvald] Learmonth, the individual who operated on King George VI for his intermittent claudication and did a sympathectomy and became KCVO [Knight Commander of the Royal Victorian Order]. He was very unpleasant. I sat beside his daughter not very long ago at a dinner and she brought it up when I told her I had known him. He'd been so difficult at home as well.

MM: He was something of a bully I think.

RK: Oh, well known to be. Very, very intimidating. He showed me – I had distinction viva in surgery and he showed me a young middle-aged individual with an enormously swollen arm with urticarial blisters scattered over it, swollen up to his shoulder. He said, "What do you think of that?" So I said, "I think he's been bitten by some insect and he has a massive allergic reaction." He says, "Yes. That's obvious. Why does it stop at the shoulder?" So I said, "I would imagine because it gets diluted as it travels up." "No, no, no. It [sustaminates]. You should know that." That's another vignette of what it was like in those days.

MM: Some people, like John Bruce presumably was still in the army at that point.

RK: John Bruce was at the Western, and I never went to a clinic in the Western. All the clinics I did were at the Royal, until I then became a house physician. But as a medical student I never went to the Western. And John Bruce was entirely there. I met him, in the distinction viva, because there were several surgeons and he showed me an individual, a man who had his groin uncovered and a swelling, an obvious swelling, somewhere around his inguinal ligament. Can't remember whether it was lateral or medial, medial I think. "What do you think of that?" Standing two yards away. "Don't go near, don't touch. Just what do you think?" So I told him various possibilities. And he said, "Alright. Go and feel it." And it was like a rock. It was a benign, either boney or cartilaginous, tumour. That's the only time I met him.

MM: Were there any others around the Royal Infirmary? People like J. D. S. [James Davidson Stuart] Cameron, other people that you…

RK: J. D. S. Cameron I did know because he was first assistant with Smart. Was it Smart? No, it was not Smart. It was Small was the first physician I met and Cameron was the first assistant. And I used to go quite often to the tape nights and we'd see Cameron but he was the epitome of didactic teaching. He would take a clinic and I can remember it vividly. 15 of us. He made us stand around this bed. He was a small man and he perched on the railing of the bedhead so he was above, looking at us. And above the patient who lay there listening to this, and he said, "This patient is jaundiced. There are three types of jaundice. There is hemolytic… " and so he went on. This poor chap had obstructive jaundice, I think. But the whole hour was spent listening to him giving a lecture on a bedhead. He was on the interviewing panel when I was made a registrar to Ted [Edward] French and he said to Ted French afterwards, "You really ought to…", because I was appointed, and I had been with Ted French already as house physician and SHO [Senior House Officer] – "You really should get Kilpatrick away to do research somewhere. Preferably away from Edinburgh. He'll never get a consultant job in Edinburgh when his father was a miner." It's amazing how it ran through the system.

MM: To the point of actually saying so.

RK: Yep.

MM: That's extraordinary.

RK: But to a degree there's some weight in it about not just going on to senior registrar because I would then have been very young and in general medicine that would've been a problem. You'd have to be an SR for quite a long time. And in fact I did go to England and spent the rest of my working life in England. But I can come to that. I think it's more important to tell you about – I've only met three individuals in my life who are quite extraordinary people for one reason or another. And the first of these that I encountered was Edward French. French was brought here as a consultant physician by Stanley Davidson who took a very deliberate decision I think to import, because Edinburgh was so parochial and looked as if it was going to continue to be so unless he did something, and he brought several individuals to the Western and the Eastern, which were the poor law hospitals. Dickie Turner came, John Strong came and Edward French. And French I think was the most recent import and after I had done house surgeon I met the woman that I mentioned I had met the first day of coming to university and she had done a house job in the Eastern, not with French with in fact the individual Robson who later became the principal of the university. But she said to me, "There's a very impressive consultant called French. I would recommend you to try and get his house job." So I went and arranged and I went and saw him. He was an extraordinary figure as well. He was like a lifeguard. He was six foot three, extraordinarily well built. Massive. Massively powerful and the most courteous, gentle individual I have ever met. And he became the major formative influence for myself in medicine. He had been trained in Guy's and he had worked with Arthur Hirst and with John Ryle while he was at Cambridge before he went to Guy's. And these two individuals had obviously influenced him, which he later in effect passed on to me and I then passed on to a very large number of people. And what he was, he was an epitome of what Ryle wrote about in a very striking book called *The Natural History of Disease,* which went in to several editions. But I didn't know the book. I knew the book later but I saw it in action watching Ted French. Ted French would go on a ward round at 9:00, 9:15 in the morning and that ward round would go on until 4:30 in the afternoon. He would sit down with every patient and before he looked at the record of the house physician, he would take a history himself. And he taught me, and I've recounted this on many occasions, that when you see a patient and introduce yourself you communicate to them that while you're seeing them, their problem is your problem and you take their problem in as much detail as you can extract. You persuade them to tell you in their own words what they have experienced and he took enormous pains to get it in the detail. And he became a legend in Edinburgh as the individual who could always, or virtually always, diagnose when others had failed. But what he mainly taught me, I mean it's obvious that this is a mechanism whereby you improve your diagnostic skill, but much more important is that it engenders trust and confidence in the patient and once you have that, you never lose it. I think it's the epitome of medical practice. And that's why I am now deeply pessimistic that it's, for lots and lots of reasons, it's disappearing.

MM: I believe he was not only an expert in history taking but his clinical examination as well.

RK: It was just as striking. As an example, I've taught so many medical students the same in later. If he said to you, "Would you just test this lady's proprioception in her lower limbs." What most medical students as they're learning, and a great majority of doctors, is they take the big toe and they say to the individual, "I'm going to move your toe up or down. Tell me which way." And they then virtually dislocate the toe with an enormous movement one way or the other, and in a pattern. Now, French would teach you that you never do that. The only way to get value out of this examination is that the patient understands it. And he would take the patient's foot and he would lift it and he says, "Can you see your toe?" "Oh yes, doctor." He says, "Now just watch me. I'm going to move it and I'll tell you which way I'm moving it. So it's up, up…" And he would do a very small movement. "Down, up, down, down." And he'd give no pattern. And he'd do it until he says, "Do you understand? Do you think you could tell me now?" And he would do it and the patient would

respond. And he would then say, “Now could you please try and do it with your eyes closed?” And it’s a piece of brilliance and I have never, apart from teaching me and teaching others, I’ve never seen anybody else do it so well. I’ve seen so many neurologists who in turn have seen me do it and realise that they’ve been quite poor. But he did it.

And another very striking thing is he was extremely good at funduscopy. He introduced and made me very interested myself in that, in fact I have a video a bit like this today of myself giving a lecture in New Zealand on the fundus and general medicine because I became so interested in – not only that, but perhaps I should add it I once gave the same lecture in Saudi Arabia, in Riyadh. I remember an individual asking me a question after the lecture and I said, “I’m sorry, I don’t think I can answer that. You realise I’m not an ophthalmologist?” And he says, “Really?”

MM: You said there were three people.

RK: Yes. Well, French of course I remained very – I remained in contact with him but I left, I left Edinburgh after I had been his registrar for… nearly three years. He introduced me to an individual called Graham [Malcolm] Wilson who was professor of clinical pharmacology therapeutics in Sheffield, and that’s where I went and did research for quite a period. I did research for… along with teaching because I was made a lecturer in pharmacology, but I did it until – for about six, seven years. And I was encouraged to apply for a Medical Research Council travelling fellowship and I wanted to go to the states to work with this individual whom I had met in this country. His name was Greep. G-R-E-E-P. Roy Greep. And he was a leading biologist and was Dean at Harvard, though he was not medical. He had done a PhD. Had an extraordinary background. Grew up in Kansas. Did his primary degree in St Louis and then came to Harvard, Cambridge to do a PhD. He laid the stepping stones – foundation stones of a very large amount of endocrinology and he was very polymathic. He did it for [inaudible], parathyroid, pituitary. He was an extraordinarily accomplished research man. He became editor of the journal *Endocrinology* and was editor for 12 years which is an extraordinary stint. Highly respected individual. Very similar physically to Ted French. His background was from Scandinavia. He was very handsome. But he was tall, like Ted. Very good looking and we got on extremely well. And I asked him if I got this, could I come and work with him and he was overjoyed because so few medical people had come to work with him and he had enormous respect for anyone who was medically qualified. It’s a feature of life that this aura that medical practitioners have. And I went there for nearly a year and a half and, I can remember, I said, “So what do you think I should do?” when I got there. I went with my family. By this time, I had three children. He said, “Well, just do whatever you want.”

I had another individual that I met in Boston, even more explicit about that reply. He was called [Edwin Bennett] Astwood. I got to know Ted Astwood very well. He was the start of anti-thyroid drugs as a medical treatment for thyrotoxicosis. Very, very bright individual who later destroyed himself with alcohol. And I remember saying to Astwood, “What do you do when a young individual like me comes to you and says, ‘Can I do research with you, Dr Astwood?’” He says, “Yes, well I would say to you, fine. I’ll put you on my NIH [National Institutes of Health] grant. Plenty money.” I says, “But what do you say when he says to you, ‘What shall I work on?’”. He says, “Oh, I tell them just do whatever you want. I’ll give you advice about your methods, but it’s for you to… because you’ll be interested in it.” He says, “I used to tell them what to do,” and then he says, “And I realised that if a chap called [Philip] Hench had come to me and said, ‘Dr Astwood, what I want to do is I want to go is I want to go and collect adrenal glands from cows and I’m going to mince them up and extract them in various ways, and I want to inject them in to patients with rheumatoid arthritis.’ I would have said, ‘That’s a pretty foolish idea.’” And he communicated to me serendipity. Because it

was serendipity to Hench. Hench had noticed that pregnant women with rheumatoid arthritis became better while they were pregnant and they had adrenal hypertrophy.

Anyway, I went to Roy Greep and he said, "Work on whatever you like." So we talked it over, because of his experience. He says, and I can remember because we talked a lot, he says, "It's never been fully worked out how the pituitary maintains the corpus luteum. A lot of people say it's prolactin but the evidence is really very weak." And he said, "If you were to think of that, the best animal to use would be a rabbit." Now I had an enormous problem with rabbits because, not only did I have asthma from unknown causes, I had found that I was allergic not to horses, I couldn't be because otherwise I would have died from the diphtheria, but I had severe allergy to rabbits. So I had to – I got a vaccine made for me by a drug firm which I had to inject myself with so that I could work on the rabbits. Rabbits have a great advantage for the particular problem which is that they ovulate on demand. They ovulate after copulation. So you can time the ovulation and the corpus luteum which follows within… starts within a couple of days of ovulation. What I had to do was to remove the hypophysis and supply either prolactin or whatever, and I looked it up. Very, very few people had ever done hypophysectomy in rabbits and get them to survive. They're very fragile animals, rabbits. If you give them an anaesthetic they tend just to not wake up again they're so, so fragile. Geoffrey Harris, professor of anatomy at Oxford, a major figure in research in pituitary end organ access came to Harvard. He knew Roy Greep well and Roy told him what I was busily trying to do and I can remember Harris saying, "Oh I'll show you how to do hypophysectomy." He says, "I haven't got much time, I'll do it on a dead animal." And of course it was simple on a dead animal, but he showed me the technique. It was parapharyngeal and he showed me various little difficulties. But I spent, of that period, I spent three or four months performing hypophysectomy and getting animals to survive and it was all technique. The major thing I had to learn was that you kept them very light during anaesthesia and you stopped the anaesthetic when you knew your surgery was going to finish in a few minutes. There are lots and lots of [dedium]. Anyway, I have a claim and I've said that to many others. I was at that period the third best hypophysectomiser of rabbits in the world, because only three people had been able to do it. One was a woman called Dora Jacobson in Sweden, who had been the first, and she had taught Geoffrey Harris, so he became the second. And he, to a degree, taught me and I became the third. It's never been done since.

MM: So, your third man?

RK: My third man is much later. By which time I'm Dean of the new medical school in Leicester, having been Dean for three years of the faculty of medicine in Sheffield. That was one of the reasons – it wasn't the only reason I was appointed at Leicester. The other way back reason is that I had met [Sir Hugh Norwood] Robson who was in the same hospital, Eastern General here, with Ted French. Robson went to Aberdeen and he then went to be professor of medicine in Adelaide and he came back to this country to be Vice Chancellor of Sheffield. I became very close with him because he was a patient, he had a lot of problems and I looked after him. He came to Edinburgh then here as principal, I think he recommended me to the Vice Chancellor in Leicester. So I became Dean. And the Vice Chancellor of Leicester, called Fraser Noble, left to go to Aberdeen within a year of my going to Leicester and they appointed a Vice Chancellor who was – is called Shock, Maurice Shock, from Oxford. And he is the third. We became almost instantly close friends. We got on extremely well. He had a particular interest in medicine even though he's a PPE man and a historian who'd spent all his life in Oxford up until then. He had an interest in medicine. He had said he would not become a Vice Chancellor in a university unless it had a medical school and the new one interested him, so he came and we got on. I was there – I'd only been there for a year. He must be amongst the ten most intelligent people in the country. He is extremely intelligent. I've met a few, two or three others like him. Edward Boyle was another that I met. They have an ability to take in a vast amount of

information quickly, assimilate it, analyse it and then give you a view. It's really very striking when you see it, what a major brain power can do. As I've said, for instance when he was chairing senate at Leicester, and he went through difficult times, times of redundancy etc. etc. And I remember one professor of Greek getting up and saying, "What a lot of nonsense. You must just continue to pay everyone and the government would bail us out." And Shock would say, and he has an extraordinary, striking mannerism. He repeats two or three words, "Well I think, perhaps what we should do, yes, I think we should do…" you know that, he's obviously… [gestures]. And then he'll say, "I think there are five reasons why we shouldn't do that. No, I'm sorry. There are six." By this time the chap's lost himself because he's going to have to assimilate five reasons, maybe six. And he delivers them, one by one. It's a very… it's entertaining, just to watch it happen. He's coming up here to stay with me in a month's time. We keep in touch. He went back to be Master or Rector of Lincoln College and he did that for a few years. He's retired now, just like - as I am. Want a break?

MM: This might be a good time to do it.

RK: Yeah.

[Interview recommences]

MM: Could I go back now to the Royal Infirmary in Edinburgh when you qualified. That would coincide almost exactly with the beginning of the National Health Service.

RK: Yes. The NHS came in to being… implemented in '48 and I qualified a year later.

MM: Was this something that you saw coming?

RK: No, I didn't. I was always somewhat fairly well read and I read newspapers from an early age so I knew what was happening but I had… I saw it as part of the Labour government. It was Beveridge manifesto and all that.

MM: I ask because that would influence the form of appointments at that Royal Infirmary and so on, perhaps not at once but gradually. Could you tell us a little bit about the mechanism of getting your foot on the ladder as it were, your first jobs and so on? How that was done.

RK: Well, I was offered a house surgeon job by Geoffrey, the chap who had examined me for head and neck in pre-clinical. He had actually approached me, I don't quite know where but he did. And he was surgeon, amongst other places, in Chalmers Hospital and I was his houseman. That was really a quite extraordinary experience because it wasn't just with him. I had general surgery beds to look after. I also had gynaecology beds with Clifford Kennedy, who later delivered our first child. He was, I found, a most attractive man. And we had ear, nose and throat which actually consisted of 20 children every Tuesday and 20 children every Friday who had their tonsils and adenoids removed by guillotine. That was I think my first major experience of responsibility, because it was my first job. The outgoing house surgeon who was Polish, he'd been part of the Polish medical school, explained the whole system in the space of an hour and then disappeared including pointing out that I had to give the anaesthetic to these 20 children on a Tuesday and a Friday. The anaesthetic consisted of a large bag into which you put oxygen, side tube and you took a vial of ethyl chloride. A very potent anaesthetic. You would then open up the valve so they would breathe a mixture of oxygen and ethyl chloride and you put the ethyl chloride into a jug of hot water to let it volatilise quickly. After the – or during the first day the surgeon said, "That's taking far too long to anaesthetise them, Kilpatrick. Just try them on the ethyl chloride itself." Which I then did. It's almost impossible to describe it but these children would hold their breath when you clamped this mask on their face and then they would take a huge breath and would pass from stage one to stage four during the breath! It was

quite extraordinary. Some of them went in to laryngospasm, and they all bled so much. I had been told to go down and look at them at two in the afternoon in the outpatient bit. I tried to begin with to look in their throat but it was pointless. They were so shocked and upset. But I rarely had a week when at least one of them would come back exsanguinated. Brought back by the mother, usually about midnight and I had to get blood cross matched. It was a dreadful experience. Dreadful. Fortunately all gone now and I really do believe the majority of them had it done for no reason. In fact, lost some immunity because of it. We now know what the tonsils do. But I was just appointed on the say-so of an individual and the same applied when I then became house physician to Ted French. From then on I had an appointment committee for senior house officer and then registrar and of course later for Sheffield etc.

MM: By the time you had qualified, had you already determined on an academic career?

RK: Yes. I was most enthused with neurology. I would've liked to have been a neurologist. But after being with Ted French I became convinced because he was the epitome of the general physician. He was good at everything. Didn't matter what the patient had, he was adept at it, skilled at it, and interested in it. And I'm sure that's why I didn't – and I knew of course as well that it's a long hard road to do neurology and you had to do it, really, down in London, and I was reluctant to go to London. I had a very difficult experience. I went to sit the London membership while I was a senior house officer. Ted French – one thing about Ted French, he had flaws. And his judgement was not good. He should have been able to realise that to send me down to London, as I was at that time with a Fife accent, unconfident, pitched into this maelstrom down in London. The first patient, the patient that I saw on my first attempt at the London membership, I didn't understand a word he said. He was a cockney. He probably didn't understand my accent either and I must've failed immediately on the long case. I'm sorry. I've forgotten what you've asked me.

MM: So, we were really just talking about your first job and you were with Ted French beginning an academic career. So, you would have to have an eye towards research fairly soon.

RK: Yes. Because it was assumed that you did do research.

MM: So, there's an expression that I heard just the other day of describing one kind of research as being just curiosity research, that is of the problem occurring to you there, it was just curiosity. Was that your approach or were you set tasks as it were?

RK: When I went to Graham Wilson I was… I got a fellowship, a research fellowship, which was jointly with his department and the radiotherapy department so in effect I had to take on an area of interest to both. So what I did was I did a follow up of carcinoma of the thyroid which I could get access to through the radiotherapy department. And in fact it was very fruitful because in so doing we were amongst the first to understand and publish that one particular type of thyroid cancer in young people, it's usually in young, followed a few years earlier radiation therapy to the thymus. So it was written up in the *Quarterly Journal of Medicine*. From them on it was Wilson's… he was a head of department and he felt that you should work on his arena which was thyroid research and thyroid problems which actually never really interested me all that much.

MM: But you would at that time then see yourself as a general physician with an interest.

RK: Well, that was another… see, I could now see that what was happening in medicine is that specialities were developing. And I think I probably foresaw that in due course general physicians would disappear. Which in fact they did. The only general physicians left are people who are in pharmacology and therapeutics because their special interest is in drugs and they therefore see all

aspects of medicine in relationship to that particular point. But other than that… that's why I think I said to myself I'll stay in pharmacology and therapeutics.

MM: Well, that takes me on to 1955. You were then 29, I think.

RK: Yes.

MM: And that's when you moved to England. Now that must have been – I wanted to ask you first about that on a personal basis because you were already married and had one child by then.

RK: Yes, yes.

MM: And therefore you were moving your family.

RK: My first daughter was born in the Simpson. I always remember the Simpson because I couldn't believe it. I'd been in the Simpson but I hadn't seen it in this respect of someone actually close having given birth. My wife was so upset. My wife comes from very close by, a village in Fife. Fastidious, elegant lady. They had no doors on the lavatories in the Simpson at that time. That is, when you think of it, is unbelievable. But it was done with this ostensible purpose, "You might pass out, my dear, when you're in there". They could easily have made an arrangement whereby they could have a key on either side or whatever. It was just… She couldn't get out quick enough. Anyway.

MM: And yet the Simpson had a reputation and prided itself on this reputation.

RK: Of course. Of course it did. But as soon as we went to Sheffield and the next two children were born it was quite different because England was so different from Scotland. It was also very strikingly different medically. That I appreciated almost immediately settling in Sheffield. It was so obvious that in Scotland the professorial departments were regarded as the leaders in Scotland. That was not so in England. They only became leaders when the general run of consultants accepted that they were as good as them, if not better. And that's a very important lesson for anybody actually still today moving from Scotland to England. But I learnt it.

MM: So was that the sort of biggest shock then moving to England for you?

RK: I don't know that I… I was sorry to leave the environment that Ted French had around him and I always had nostalgia for that. And I think I also tried quite hard to try and create it around myself but it was difficult because it was not by any means universal amongst my colleagues as other registrars and later consultants. I also, like Ted French - I mean he regarded research as being something that you would do if you were really interested in a particular problem. Not something that you had to get certified for. And I think I always felt that myself as well. I think it's also a reason why, when I later, in effect, gave up research, when I became Dean at Leicester, I did it without any great pang of regret. I have, perhaps I should just say, because I have one particular experience which encapsulates what I learnt from Ted French and what I hope I've passed on. This has been recounted before for anybody who's watching this video at a later date, they'll probably have heard it elsewhere. Ted French went on holiday. In those days, it was… he had a staff, only a house physician and either an SHO or a registrar, and a part-time senior registrar who really you didn't see much of. So I had to do his outpatients for the month he was away. This was in my… I'd be a second year registrar by this time. And a lady came up, Friday afternoon. I can remember all the details. Doctor's letter. "Sorry to send this lady up but I just can't get any further with the problem. She's already seen four consultants, two of them psychiatrists, in Edinburgh and we've not been able to… find a logical conclusion. This lady, she was 52, her complaint was tiredness. Now tiredness is a very difficult… it's a bit like… Matthews, the professor at Oxford who wrote a very nice book on neurology

who says in a chapter on dizziness that every consultant physician who knows that the patient coming in who has got dizziness is hard forced to his boots. It's such a difficult complaint and so is tiredness. It can mean you're sleepy, it can mean you're fatigued etc. etc. etc. And I spent – did what I had been trained with Ted, took as long to get the detail from her, but she was not very articulate. And eventually - I never did symptomatic history because Ted French never did that but he would always ask everyone about appetite, weight, [bituration], bowels, sleep and menses in women. So I said to her, "How is your appetite?" Never ask a leading question. And she said, "Oh, my appetite is good, doctor. I enjoy my food. But I sometimes get tired when I'm eating." So I said, "You become tired?" She says, "Oh yes. I put my hand under my jaw." Symptomatic of myasthenia gravis. But it had taken a long time to find the key. So I remember I said to her, "Well, I can confirm what I think is wrong with you with an injection. Is that alright?" "Anything, doctor." Another feature of patients I think is all this nonsense about giving them the ten… So we gave her pyridostigmine and it works so quickly and within a minute she said, "Oh, I feel strong!" She couldn't get weak. Weak was not a word she could summon. So what she meant by tiredness was she was weak. She says, "Oh, I feel strong. Can I get up?" So I said, "Yes." So she got up and walked around the consulting room and she said, "Oh, that's marvellous." And she started to dance! And she danced around and she came up to me and she said, "Dance with me, doctor." So I got up and I danced with her! Future president of the General Medical Council dancing with a patient in the consulting room! But that's what I really want to convey is that she totally trusted me. She had total confidence from this whole experience and she remained like that until her death because she had a thymoma. But it's illustrative of a really very striking feature of medical practice when it's done well.

MM: So, one does get the impression that at that time right up to the point of getting a chair you were still a general physician.

RK: Yes. I was.

MM: So the next question was an impossible question I suppose. Just what was it like to move in to your first chair?

RK: Well, I think again it is related to what you experience. I was aware in Sheffield that there were professors who regarded themselves as omnipotent and omniscient. The most striking example was Illingworth. Now, you'll know his name. He was professor of paediatrics. And it would be within my first few weeks, they had a travelling grand round in Sheffield to the different hospitals. And I went to this one which was in the Sick Children's run by Illingworth. And they showed various clinical problems and one of them was I think a lymphoma. It was either lymphoma or a non-Hodgkin. What's the term? Oh, don't worry. It's related to Hodgkin's. And he turned to me and he said, "Now, you're the new professor of therapeutics. What treatment should this child have?" And I said, "I'm sorry, I don't know. I'm not really conversant with what treatment of this condition is." And he obviously regarded me as a simpleton. But I wasn't a simpleton; I thought he was simple to expect this kind of… But he was always like that. He always knew. Whether he did or not, he always knew. And I've always been aware that one's knowledge is really… It's related to your own experience and it can never be catholic. For one thing it's always changing, and I think it's also related to my rather low self-esteem and confidence. I would never pretend to be something that I'm not, which I think a lot of professors do.

MM: Did you inherit a department or did you have a lot of building to do when you went?

RK: No, in effect I inherited the department when Graham Wilson went to Glasgow. I was head of that department until I went to Leicester which would be about seven years? But it was already established and running department. I'd also become by that time interested in the administration

of a larger unit, namely the university, rather than a department and I had become very conscious of the powers of heads of departments. You know, the rubber baron theory and I was very anti that system. We started at that time a novel arrangement in Sheffield called an academic development committee where the vice chancellor was a member but not the chairman and it was meant to allow development on academic grounds, academic merit, rather than the power of heads of departments because I had seen some extraordinary things, of heads of departments becoming too omnipotent really. And I was in fact elected chairman of that committee within a couple of years of becoming head of department. And I did that for four years I think.

MM: How was that received?

RK: Oh well. Yes. It was regarded as a major development.

MM: And did anybody else follow this? Was it an idea that was taken up?

RK: That I don't know. It's certainly been talked about at inter-university conferences because I spoke about it. I would be surprised if it hasn't had some major influence.

MM: And having done that there, what was the motivation for moving then?

RK: Well, I had been dean of the faculty of medicine in Sheffield for three years. I had just… I was in the first year of having given it up. There's a very real phenomenon, which I have seen many, many times, that once you've held an office it's quite difficult to go back to where you were before you held the office. I've noticed it with vice chancellors, they really have great difficulty going back. And I was perhaps a little unsettled returning to just being head of department. And I had also finished this academic development committee as chairman. And I was approached, written to by the vice chancellor in Leicester, to say… in fact the first dean of the new medical school, called Crammond, had only been in post for two years and the students had not yet appeared. This was '74. The first students were not until '75. And Crammond had just been made principal of the University of Stirling. I think very much on the basis that after the [spitting on the queen] a number of people including myself said, "Well the next vice chancellor will either have to be a policeman or a psychiatrist." And Crammond was a psychiatrist. Anyway, he left and the vice chancellor wrote to me and said would I come down and discuss it with him. So I thought, *Nothing to lose*. So I went down to Leicester. We discussed it, just the two of us, and he said would I come back and discuss it with the few staff that had already been appointed. There were maybe about six of them. So I said, "Yes, alright. I'll do that." So I came back and did that. It was a very unusual interview because in effect it was myself interviewing them, rather than the other way around. And then he contacted me and said they'd like me to come. So I said, "Well, I have to think about it." And I remember I rang Sir Hugh Robson who was now here as principal and had recommended me. So I said, "What do you think I should do?" He said, "Well, I think Robert it shows you're clearly interested to a degree in medical administration. Why don't you do it?" He says, "I would write down your conditions. You never go to these kind of jobs when you're invited without laying down conditions. After all, you don't need to go." I later found out that the conditions were so severe that they took them to the treasurer of the university, a layman, a very interesting fellow in himself. A German refugee who had developed a method of adhering rubber to metal which was used in the minis etc. A nice man called Goldsmith. And he had said to the vice chancellor, "Well, do you want him?" And they said, "Yes, we do." He had said, "Just let him have them." And I learned that that is how the world works to a considerable degree. If they want you, they'll try very hard. So I went to Leicester. I was also interested because it was a new medical school. And there was no pattern. No pattern had been set down.

MM: That was what I was going to ask. What was there for you to take over?

RK: There were as I say about six departments. Mainly the preclinical and two medicine and surgery. One of them was Peter Bell who just not very long ago got a knighthood. He was professor of surgery at a very young age, he was only 32. What had to be done was to ensure that the financial resources would come because the financial resources were, certainly from the university grants committee, for the actual academic departments but the bulk of the teaching was always going to be done in the National Health Service. And it was the interface with the National Health Service that I was particularly interested in because I had seen it a bit in Sheffield and it was quite difficult. The interface was not very happy. It was dominated by the private physicians and surgeons. So that's what I had to do. I had to become the university representative on the regional health authority. I had at the same time liaison with the local Leicester officers, the chairman, the chief executive, the treasurer etc. etc.

MM: And this sort of interface as it were with the people in private practice. This was, do you think, materially different from what we are accustomed to in Scotland?

RK: Oh very much. Very much. There was virtually… I to a degree knew it but I got to know it much more in detail that while I was here in Edinburgh there was hardly any private practice because there was no demand because the resources in the National Health Service were so great. You'll know, most people know the figures that compared to the average it was 120% in teaching hospitals all over the country but it was of an order of magnitude greater in Scotland. It was over resourced. Well, it was over resourced in relationship to what was in England. So there was very little. There was a very large amount – Leicester had always been a major private… an arena of private medical practice. And the development of the academic departments changed the face of it considerably. A very good example was obstetrics and gynaecology. They had a very poor perinatal death rate. Within three years of the academic department and with John McVicar who you'll know, the perinatal had fallen considerably because they all had to devote much more time to the National Health Service. So it was a changing, improving, exciting time.

In addition there was the pattern from the medical students. And that was because the curriculum had been laid down by a group, chaired by Andrew Kay from Glasgow, and they had been convinced that in preclinical they should not only have the standard subjects but that they should have a course called *Man in Society* which would stress psychology, sociology and the relationship of patients to their environment. And medical students in Leicester became very questioning individuals because of that one course. We had General Medical Council inspectors coming every year while the first cohort went through before we would get our license from the General Medical Council as a recognised medical school. And one of those examiners was Bill [Raymond] Hoffenberg and he was a sceptic, total sceptic, when he came. Said he thought this was a lot of nonsense, *Man in Society*. And he left totally converted. Very striking. The best vignette I know from this was one of the part-time general surgeons in a clinic and one of the students asked him, "Why did you bring this patient into hospital?" And the surgeon said, "I'm the one that asks questions, not you." [Laughs] And that was a… it ran as a thread, a major thread, through the time.

MM: And could I just go back to this interface with the private practice. I mean how – was there any active resistance to this or did it run reasonably –

RK: That was very striking is that though it was a major feature… there was a general enthusiasm to have a medical school. I think that was because they knew that if the medical school came, NHS resources would come. And, in addition, they had two or three leaders in the NHS who were particularly keen and one of them was called Kenwood, became a very great friend of mine. He was

a surgeon, did a lot of private practice, but an excellent surgeon. And he was on the Kay committee setting up the curriculum and he was always supportive. All the time.

MM: And how about the students? Did they come actively or did you have to sort of… I won't say advertise but you know, did you have to have –

RK: No, we never had to do that. I was not involved with the choosing of the first cohort. But it's an interesting feature in itself. Crammond took the view that the one thing that you must not do in selecting medical students is to interview them. And I went there and took the view that the one thing you must do in selecting medical students is to interview them because in effect you're going to make them like yourselves, the Pygmalion principle, to some degree. And I think you want to see what kind of people they are. I was also very interested in terms of what social class they were coming from, from my background etc. My academic colleagues accepted this but we did it on a very unusual arrangement. We did it on a one-to-one interview. All others that I had seen had a panel of three or four or more people. I did it on a one-to-one. There can be flaws in it but its major feature is it's like being with a patient. You eventually get a great deal from them if you're prepared to give the time and we gave them at least half an hour. I had learnt this in Sheffield where I had… before I became dean I was put in charge of admissions, by myself. They had abandoned some years before the interview system and I restarted it but I started it on a one-to-one. I read every application myself. I had a few trusted colleagues who interviewed with me but on a one-to-one. And let me just tell you about this interview because it's really very striking. I had an application from an individual called Pucholt. Vladimir Pucholt. Nationality Czech. He had listed – you're allowed five choices – he had listed four London medical schools and Sheffield. Turned it over, there was a referee report and the referee was Lindsay Anderson. Now Lindsay Anderson I knew, because of an interest in film, was a leading film and theatre director. He had directed the film *If*, a most extraordinary film of a revolt in a public school against the public school system. So I read this and it was an extraordinary reference because it said that this individual had stowed away from the Czech regime on a plane. So I said, "Let's ask him." So he came and he came in with a motorcycle helmet on his head, took it off and he showed what Lindsay Anderson, who I later met and talked to a great deal. I remember saying to him, "How did you spot Malcolm McDowell?" Because he was the one that introduced Malcom McDowell to film. He says, "It's easy, Robert. You've never any difficulty." He says, "If you're seeing 500 people walking in to a theatre or into a big gymnasium, you'll spot Malcom McDowell. He'll hit you." And he's right. And this chap hit me. It was quite extraordinary. So I said to him, "Tell me, how did you get here?" So he said that he had become 18 in Prague and he wanted to do medicine. It was iron curtain days, clad iron regime, and he was told he couldn't go to medical school, couldn't go to university until he had expiated by working in a factory or a farm for a year. So he did, in a factory. And he reapplied and was told that he could now go to higher education but not to medicine, that was not on. And they offered a range of topics and he chose dramatic art and in five years he became the leading Czechoslovak actor and he's in the early films that Milos Foreman, who did *One Flew Over the Cuckoo's Nest* in Hollywood, who had made these films in Czechoslovakia and he had become his leading male actor. *A Blonde in Love, The Fireman's Ball* – these are films. And he met Lindsay Anderson in Prague at a big film conference. They talked and this Pucholt told Lindsay Anderson, "I don't want to be an actor, I want to be a doctor." And Anderson said, "You must be mad. The world's at your feet! If you can get over to the US, you'll…" And he said, "No, I want to be a doctor." And Anderson, who's now dead, did something I think quite extraordinary. He said, "If you can get to England, I'll support you." And he supported him financially for six years of medicine because he had to do first M. B. because he had no biological training or chemistry at all. I then said to him, "Why did you choose Sheffield?" And he looked, he blushed a little. And he said, "Well, I have a map of England and Wales on my wall and I threw a dart at it." [Laughs] And of

course he'd aimed for the centre and it was Sheffield. So we took him. He had a tough time first year. But he graduated with the gold medal and he's an example of polymathic talent. Whatever he did, he would be –

MM: And drive.

RK: And drive, which is part of polymath. He's a paediatrician in Canada now. And he, most extraordinary… Lindsay Anderson died while I was president of the General Medical Council. So I was in London. And they had a memorial, a very unusual memorial in the Roundhouse, the theatre. And I was asked to go because Pucholt came as a protégé to contribute and I was a guest of Pucholt. And there I was sitting in a theatre with Alan Bates, Alan Bennett, Maggie Smith, all these who had all been – all worked with Lindsay Anderson and obviously he was a very influential individual. And Pucholt went up and he recounted his interview. There were gasps when he said, "And he said to me, 'Yes, you can have a place'." And it was one of the best decisions I ever made.

MM: …the students. Did they sort of come together quite regularly, then?

RK: Oh yes, Leicester became attractive. I think it was attractive because their own state schools realised the significance of what was being done with this curriculum, and especially *Man in Society*. It tuned in with the times so we never had – we had big demand. We would be selecting one out of four, that sort of number.

MM: So you were then dean again.

RK: Dean again, a long time. I was dean until I left because I was a full-time dean. It was never suggested that it should be a rotating system. I would be the dean and I would do it for as long as the university authorities were in favour and I was in favour. So I did it from '75 until '89 and I left in '89 simply because I had become - been elected president of the General Medical Council so I had to leave. That was full-time as well.

MM: We could talk about being dean for a long time but I'd like to move on to the General Medical Council. How did that fit? Where did that come from?

RK: I had been on the General Medical Council… if you go back to pre... there was a Royal Commission on the General Medical Council chaired by [Sir Alexander Walter] Merrison. It was called the Merrison Committee. I was on the General Medical Council before Merrison because at that time there were 48 members of the General Medical Council, half of whom were elected from the medical schools and I was on from Sheffield. So I went on first from '72 until '75. I then had to give up because I had become dean of Leicester and Leicester couldn't put anyone on until they were licensed so I was off for four years. But as soon as we got our license I went back on to the General Medical Council which was now post medicine and had enlarged from 48 to 104 with a medical majority, which had been a feature of the Merrison enquiry because the argument had been made about the General Medical Council pre medicine that it was asking for subscriptions even though the bulk of the profession had no election rights. Or they had very few. I think some six people were elected from the bulk of the profession. So it was very much like the United States, no taxation without representation. So it was now a big group, it was 104. When I first went on Henry Cohen was the president; an austere, distant chap I never really got to know. But when I went back on [Baron John Samuel] Richardson was the president and he saw in this new large body very well. It functioned well. And I just went through. I became chairman of the health committee, almost by default because the individual who was likely to become the chairman was a psychiatrist in Glasgow who developed a stroke a few months before the election. So I was chairman of the health committee and I then became chairman of the education committee. And then there was the

election of president when John Walton gave up. But that election of myself was an interesting… I had no ambition to be president. I was aware of, acutely aware… if I were asked I've learned various lessons in life but one of them was to strive after anonymity compared to what so many people strive the other way to get in front of the media. And I was quite keen to remain anonymous. I knew that the president couldn't do that. You become a public figure. But there was a large enough group of people on the council trying to persuade me to stand. Now this would be going on for about a year before John Walton finally gave up. The other major contender was Anthony [Grabbum] who was an extremely influential figure on the British Medical Association and it became quite clear that there was, in effect, an attempt through him for the BMA to take over the GMC. Because that's what it would have become. At least that was the view of a lot of influential individuals, so I was put under a lot of pressure. By strange coincidence, at or around the same time, it must have been, the election to the General Medical Council was going to be in November and [Sir Raymond] Bill Hoffenberg was giving up as president of the College of Physicians [of London] in September because he came to me midsummer and said, "There are a very large number of people who want you to follow me, Robert." So I said, "Well, I can't do both. You realise that I'm being put under pressure to do the General Medical Council?" He says, "Yes, I'm aware of that. It's up to you." Well, I'm not sure if people believe me but I was not all that keen to be president of a college because its ceremonial aspect is enormous and I'm not - really not keen on ceremonial. I was also under this pressure and I began to be aware that it was a real phenomenon, a real major change would occur if [Grabbum] was appointed. So I stood and I was appointed by a clear majority. Major majority.

MM: And if it's not a mischievous comment but wouldn't being president of the College in London be somewhat foreign territory for you in a way?

RK: It would have been. Particularly when I failed the membership the first time [laughs] because I couldn't understand a cockney accent.

MM: Because one's impression there is heavily loaded with Harley Street and private practice is it not, to some extent?

RK: I think that had changed.

MM: Had it?

RK: It had changed a good deal earlier. It was the change of presidency. When Douglas Black was appointed president I think that's when the change began and even more so when Cyril Clarke was appointed president. Cyril Clarke was not a private operator.

MM: That was not a –

RK: That was not a feature. There was still I think of course more than the private aspect is the London aspect. They had to - to get Cyril Clarke appointed, they had to - there was a fleet of buses from all over England bringing people in because you had to vote in person. It was a well-known feature at that time. I don't regret that decision at all. I don't think I could have done it well actually.

MM: There will be people looking at this film who know very little really about the General Medical Council.

RK: Yes.

MM: Can I revert to that rather fatuous question – what was it like?

RK: Well, it has two major functions. It has one major function to begin with, well set out by an early president around 1900. It was set up in the public interest. It was not set up for doctors to look after

doctors. The initial task was to rationalise the standards of medical qualification. Not well known that in 1858 when the act of parliament was passed, there had been 18 attempts to get an act of parliament to set up a General Medical Council resisted by virtually all medical schools, especially in London. Pre-1858, if you qualified in London you could go and practice anywhere. If the qualification was by the University of London you could go and practice anywhere except London, because the College of Physicians would prevent you, because they had their own qualification. It was a mess. Anyway that's what the General Medical Council did in its first 30 or 40 years. It rationalised and produced an overall reasonably uniform standard of medical education so that the public could confidently say, "Yes, he'll do it as well as he can, or she can." And then it followed on, having done in effect medical education, it followed on that there had to be something done about the offenders of medical conduct, medical practice. So the whole fitness to practice machinery slowly evolved and it became eventually the major function. And certainly the major function financially, that was the cost that the profession had to bear to achieve this mechanism. It had one glaring anomaly, well pointed out by a woman whose name I forget now. She used to write in *The Observer* Sunday paper regularly. She said, "The General Medical Council can do anything to a doctor. It can strike him off for adultery, it can strike him off for sexual misdemeanours, it can strike him off for being drunk in charge of a motor vehicle. The one thing it cannot do is it doesn't know what to do… it doesn't know how to deal with a bad doctor." In other words someone whose medical practice was, day in day out, below par. Now that's due to the fact that when the conduct machinery was developed before the turn of the century, 19th to 20th, they adopted, through the privy council which is the overall umbrella of the GMC, the criminal rules of evidence and the criminal burden of proof. The burden of proof is you must be beyond reasonable doubt and the rules of evidence are the adversarial system that we know runs the criminal justice system in this country. Now you can compare it with an aspect of criminal justice. You cannot charge an individual who drives a motorcar with being a bad driver. You can only charge him with specific events. "You on day so and so were in charge of a motor vehicle and you drove without due care and attention or by dangerous driving." Etc. etc. Egregious events. And it still is so. You cannot make a charge in relationship to a constant performance. And this was an anomaly, a major anomaly. And I remember Ken Clarke, who was Secretary of State for Health, saying to me, I'd just become president. He says, "You're going to have to do something about this. There's too much media attention. If you don't do it, parliament will." I faced it within weeks of becoming president. *What am I to do about the poorly performing doctor? We've got the mechanism to deal with the chap who on day so and so refused to go and visit a patient etc. but the individual who's always slightly rude, always offhand, always…* and so on. And the answer, after a lot of analysis, and I was helped a great deal by Maurice Shaw, the - because I asked him to help because he was such an intelligent fellow, was given by our health procedures because you don't charge a doctor with being in health, in poor health, sufficient to interfere with your medical practice on day so and so. It's ill health over a long period of time. You can't charge someone unless you have evidence that he's been alcoholic or psychiatrically ill but over months or years. And the privy council had accepted that feature of health so I had to convince them that you could do the same for performance. And it ended up, I remember vividly going to see three of the Law Lords because it was now going to get parliamentary time and I had to persuade them that this was reasonable to try, and one of them, [Baron Johan] Steyn, said, "It's a very interesting concept. If you're successful, and I have some doubts whether you will be, but if you're successful we could apply it to the bar very well." Because it applies to all professions. So that was my major task and in terms of if I get any footnote in history, that's what it would be because I spent a lot of time. And I eventually had to persuade the Conservative government to give parliamentary time, even though they had been agitating, like Ken Clarke, that we must do this but then once you've done it, it's to convince them you must get parliamentary time. William Waldegrave supported it and he would

have pushed it through but then he was change, it's always reshuffling. It's quite a difficult business to get parliamentary time.

MM: That was a very major achievement and component, but could you give us some idea of the magnitude of the job? I mean you mentioned money for example, what sort of budget are we talking about? Just to get some idea of how big this organisation is.

RK: Well, it changed rapidly as well. The subscription from every registered medical practitioner, and that included people registered but who were practicing overseas, was around £50 annually when I took over. It's now today around £400-odd. The total turnover is – well, there are 140,000 registered doctors, you work it out. It's a considerable number of millions and it changed. The subscription had to grow because of the conduct procedures. We had, very quickly after I became president, we had this infamous case of individuals selling their kidneys for transplantation, and they came from Turkey. That case cost the General Medical Council over a million pounds because of the adversarial system, employing first class barristers etc. etc.

MM: And as the president obviously this would be a major part of your time.

RK: Oh yes. The president is a member of every committee. He has the responsibility to ensure that, especially in the finance committee, that the – even though there will be another chairman - that we remain solvent. He's obviously an influential member on the education committee and the standards committee. Let me just give you a good example because it's not actually within the General Medical Council but it is related to it. When I became president of the BMA [British Medical Association] for a year, I went to their annual representative meeting and there was a motion or a lot of debate about how wrong medical schools were to be insisting that they test medical students for hepatitis B in case they were the rare instance of the actually infectious and could conceivably infect patients. And this motion was that this was an abuse of human rights etc. Now the president of the BMA doesn't speak much, he's just ceremonial I would say. But I went to one of the main protagonists after the debate, who's just been standing, he was almost elected. James Johnston was elected last week but Sam Everington was the individual. So I said to him, "Sam, can I just get an appreciation of how much you feel about this? Obviously you think that medical schools can gear their courses for people who have particular problems. Would you for instance think that we could take medical students who are blind?" And he said, "Oh yes, certainly. David Blunkett's doing a great job." So I said, "David Blunkett has the most supporting structure of any minister there has ever been. People have to select from all the newspapers what they think he should know, and he has to get all of his information through braille etc. What would we do with a medical student? And in any case, where are they going to practice?" He says, "Oh, public health." But that's… medicine has been changing and that's a serious feature, I think. Just as I think we've lost the French… natural history of dealing with medical practice. I think we've lost that a lot.

MM: I don't think you were a particularly enthusiastic BMA man.

RK: No, I wasn't. I was always known as being the opposite.

MM: Now viewing your year in office, have you any particular observations about the BMA?

RK: Well, it was made clear to me when they invited me that they expected the president really to be largely a ceremonial figurehead and not expected to take part in the major debates, but they liked the imprint of a leading academic. I don't regret it, strangely enough. One, because I think that the colleagues that were there as it so happened were pleasant, agreeable. Sandy Macara, Richard Smith as well, even though I had lots of arguments with him, but I always had very good natured arguments with Richard Smith. But I think what I also liked was when I was sent to other countries. I

was sent to the Republic of Ireland and that was marvellous just to see how different it can be. I mean I was asked to go to the annual meeting of the Irish Association. 4:30 it will start with the annual general meeting at the hotel in Killarney. When I arrived at 4:25 there were only six people! There were still only eight when the chairman said, "Well, we really should start but I'm afraid we're not a quorum." [Laughs] And they were all on the golf course! But I like the relaxed way, I enjoyed it. And then I was sent to Australia, very unusual, it was the centenary for '98 when I was president of the Western Australia Medical Association and so they were having a joint meeting for a whole week of their centenary, local and the Australian federal Medical Association. So I was invited for that. My wife came with me and we had perhaps the most enjoyable week we've ever had anywhere. It was in Perth, lovely city. And a most agreeable set of people. Marvellous people. I'll put it on because you might as well hear it same as so many people have. They asked me to give an introduction because all of the associations in Australia, the state associations, were originally BMA groups and the mother country oversaw them. So I pointed out that the Western Australia, which said they were 100 years, didn't get the imprint of ratification from the BMA until 1899. So I said, "I thought I had to write to you and say, "I'm sorry, it's not your centenary. It's next year." But then I thought, *well I'll be out of office by then and I won't get to come* so I paid no attention." And they loved that, they thought that was very nice. And then they asked me to - what would it be... Oh yes. At the end of the Western Australia three day meeting I was asked to give a sort of summing up view of the conference, which in fact was very good. And I said, "The only apt thing I can think of to describe your conference is something that happened to me in Atlantic City way back in 1961." So by this time it was nearly 40 years. Not 40, 30 years. Yes, nearly 40. At that time Atlantic City held annually a meeting of all the major biological societies of the United States. All in the same fortnight, called federation proceedings. If you go to a big medical library you'll see the collections of all the papers that were given at these federation proceedings over many years. It broke up; it disintegrated because it became too big, later. But they had big plenary sessions for all individuals who were interested and I went to one of these, it was a plenary session on risk. Something I haven't mentioned is that I was chairman of the advisory committee on pesticides for many years which gave advice to government departments about new pesticides. So I was interested in risk management and I went in to this, there was about 2000 people in this enormous hall in Atlantic City and they had a very earnest young man on the stage telling them about his particular concern which was a product of nuclear fission which is a radioisotope of zinc, called zinc 68. And he showed very elegantly what happened when human beings ingested zinc 68 because he was able to do [radioasics] and he showed very clearly that it was concentrated selectively in the testes. And he had a picture of into the stem cells and then a day or two later into the first product, then the second product and then into the spermatozoa. And he then - and it's a lesson I've taught others, you never ever ask a rhetorical question to a large group. Because he said, "Just think, ladies and gentlemen, what that must do." And a voice floated out of the audience, "Probably galvanises them." [Laughs] And I said, "That's what your conference did. It galvanised." Oh, they loved it.

MM: But the BMA was one quite limited -

RK: Yes, it was a side effect really.

MM: But the highlight was the GMC do you think?

RK: Oh yes, that was the major task.

MM: And led on to no fewer than five honorary degrees.

RK: Yes.

MM: So I think in recognition…

RK: Yes, they came… the honorary degrees all came I suppose... Trying to think when they started. I think Edinburgh was before I became president. The House of Lords is undoubtedly related to that. When the second reading came, it was an amendment of the medical act, the previous medical act. Baroness Jay, who was in opposition at that time, who later of course with the change of government became leader of the house. She, in welcoming - as you do at second reading, there's no great debate you just hear people speak - she said, "I really think we ought to say that this is not a government bill, it's a private member's bill. And the private member is not even a member; he's the president of the Medical Council. He's done it." And it's in Hansard. And people have been trying to say that they actually… were more influential. It's historical. It's in Hansard.

MM: I think that's an excellent high note to stop on. Thank you very much.

RK: A pleasure.

MM: It's been very interesting.