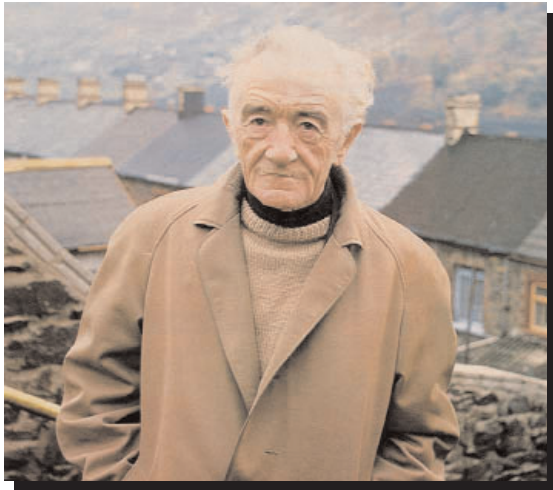


Extract from: *Health and Social Service Journal*
November 24, 1978
pp 1336-40

“Health Thinkers: Man of the Rhondda”



Dr Archie Cochrane

Health and Social Service Journal – A weekly review of hospitals, community health and residential care.



THE HEALTH THINKERS

Dr Archie Cochrane is synonymous with modern epidemiology, being one of its founding fathers. A brilliant scientist and unyielding critic of the health service who has fought a 30-year war against waste, he is perhaps best known for his seminal work in the Rhondda where he screened an entire community. This latest article in the Health Thinkers series traces his eventful and, at times, dramatic career; records some of his thoughts; and looks at the powerful impression he has made on the service.

The ancient warrior and his battles of the past and present

ONE OF THE more glorious moments in Dr Archie Cochrane's year of 1978 came when a reporter from the local newspaper 'phoned him to ask if he would mind terribly writing up his own obituary.

Cochrane being Cochrane immediately acquiesced, relishing the dark humour of the invitation. Also it was the sort of twilight honour reserved for those who are both famous and a bit eccentric.

For the man who rocketed epidemiology from the basement of weird tropical diseases to an impressive force in the medical and scientific establishment is all of that and more.

He is poet, humorist, sculptor and gardener. But most of all he is a scientist, having set himself up by example and consistent nagging, as the

conscience of the movement towards efficiency and effectiveness in the health service.

He has been described by friend and foe alike as both flippant and fanatical, a nice trick which only people with Cochrane's elusive persona can get away with.

Cochrane also likes to think of himself as a heretic, perhaps a bit toothless now but still capable of licking you into submission in his elegant and courteous style. He says rather mischievously: 'I am getting rather old and we don't seem to be producing any young heretics. Are there any coming along? I haven't come across any.'

If Cochrane is a heretic then he is a beloved one and hasn't done at all badly from it. Not many heretics can

boast such establishment scalps as being a Fellow of the Royal College of Surgeons; the first president of the Faculty of Community Medicine and MBE and a CBE; to mention but a few. It is either a tribute to his duality or simply that he is a man without rancour and in his tussles with the gods he has left no scars.

He was born in 1909 to do well. The first son of a first son of a first son of a small tweed manufacturing dynasty in Galashiels, he was quickly designated for greater things.

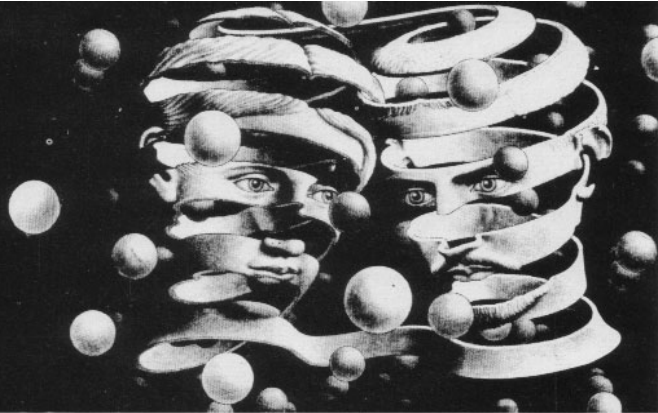
'My father was killed in the First World War and I hardly knew him', he recalls. 'As I was the eldest son, my family thought my mother would spoil me. They decided that I should be sent abroad to school.'

'As England wasn't far enough they discussed Wales or Ireland and I ended up in North Wales at rather an amusing little prep school.'

Hope fulfilled

From there the gifted youth was effortlessly to win scholarships first to Uppingham and then to King's College Cambridge, where he obtained a first in both parts of the natural science tripos. It seemed that the young Archie Cochrane had more than fulfilled the hopes of his ambitious Borders' family.

But the early thirties was a time of



harshness and dreams. Cochrane at that time was very much the dreamer, a romantic — and like many other of his intellectually aristocratic contemporaries who graced Oxbridge, he felt the sap of radicalism rise in him.

His first essay into the unknown was an abortive attempt to study psychiatry in the shadow of Freud in Vienna. 'Freud just published at the time and it was a fascinating thing to read. So I started training in psychoanalysis but I couldn't bear it. After all, you can't test his hypotheses.'

Cochrane's last remark is possibly retrospective but certainly his disillusionment was indicative of the devout empiricist that he was to become. To this day he is still interested but uncomfortable in the world of Freud because of its lack of scientific landmarks.

Freud was not the only deity to get the benefit of Cochrane's inquiring young mind. The other great godhead to be embraced by him was Marx, although Cochrane never actually took the plunge of joining a recognised socialist party. He explains:

'I took to socialism because of the terrible unemployment in the thirties. It was also beginning to be pretty popular in Cambridge at the time.

'I also went abroad quite a bit and came across Fascism which frightened me. I considered joining the Communist Party which was quite fashionable in London at the time. But I was vaguely worried about it.'

But if Cochrane was uncertain about which socialist mast to nail his flag to, he was certainly no theorising dilettante. For in 1938 he joined the International Brigade in the Spanish Civil War to put into action his beliefs.

He spent a year there and took part

‘Like many of his intellectually aristocratic contemporaries who graced Oxbridge, he felt the sap of radicalism rise in him’

in at least five major battles. The experience was salutary in that instead of giving him a solid political base it was the beginning of a loss of interest in dogmatic politics and the emergence of a gradualist philosophy which was to be central to his whole approach to the health service.

'In Spain I was wholly immature. I found some of the things there attractive, especially the anarchists who were the most interesting group. I also met all the very best people there, including Orwell.

'But I got a bit disenchanted by the political intrigue, the witch hunting and the general disunity. It all became very depressing.'

But if it was a chastened Cochrane who returned to London, the echoes from that experience still carry with him today as he argues with his colleagues about the best way of approaching the NHS.

'I have given up any attempt to change the world as I once wanted to do and this is where I disagree with my Marxist friends. I feel that I should just concentrate on changing a small bit of it. Its a bit more effective if one does it that way.

'Of course the others would argue

that you will never have a good health service unless you change the world. But I think there is room for both of us. I feel that nothing they will do will help make the health service more efficient or effective but they might help alter society so that the health service can run in a better world. Certainly there aren't enough critics in my profession.'

On his return to Britain, Cochrane qualified as doctor at University College Hospital. A trained biologist he took the medical degree in order 'to do research on people — who are much more interesting than animals'.

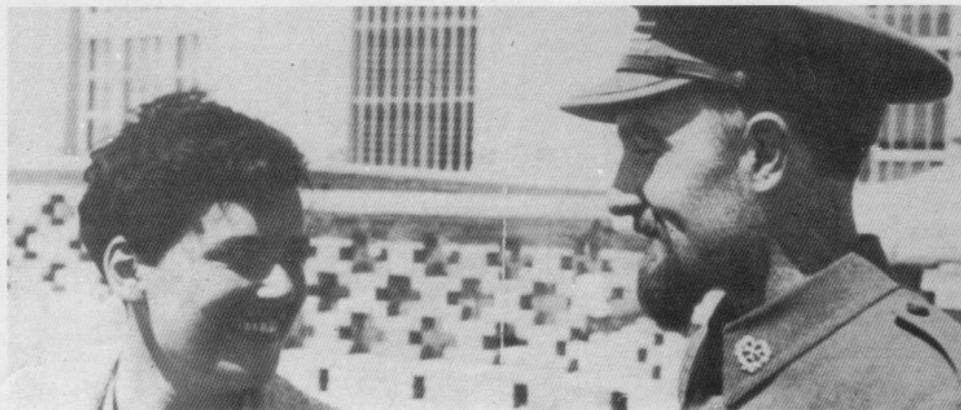
But just as he was settling into medical research and serving briefly in the medical unit at University College Hospital, his world went through another upheaval as war broke out. His was to be a short passage to arms as he was captured at the battle of Crete and for the next four years of his life he was a prisoner of war. Traumatic it certainly was but it was valuable in moulding his values and beliefs.

As doctor in charge of thousands of patients of all different nationalities suffering from hunger and TB, it gave him an excellent if reluctant opportunity to study a defined community.

'I got attracted to epidemiology by studying everybody in a community, beautifully defined by wires. I was lecturing in Germany recently and I thanked them for leading me into this productive field as a prisoner of war.'

But behind the humour there is pain and hard lessons learned. Experiences of prisoners praying for jaundice so that it would stop their hunger pangs; and most of all experiences of what care was really about.

Cochrane will never forget the day



The past — Cochrane (bearded above, seated below) joined the Spanish Civil War in the fight against Fascism



he first met a Russian prisoner. The man was in great pain and was dying. Cochrane at that time could not speak Russian and he was desperate to calm the screaming prisoner.

'I had no morphine so I gave him some aspirin. That didn't work. In despair I sat down by his bed and just took him in my arms and his screaming stopped at once. He was just lonely. He died in my arms a few hours later.

'After that we arranged that if anyone was dying we always had someone, especially if they could talk his language, to sit next to the patient and hold his hand. It made an enormous difference. If you can't cure them you might as well care.'

This reveals the caring side of Cochrane and one not as celebrated as that of the tough epidemiologist. But it is no less important.

He believes that in this highly technological age medicine has forgotten its limitations. He would like to see a move towards community hospitals to care for those who have diseases that just cannot be treated.

'It's hopeless and silly to keep such people in a technological centre. They just want good nursing and care, to be near their homes and their relatives.

'It is intolerable that a whole family has to travel thirty miles by car just to watch granny dying.'

He is impatient of critics of this pragmatic philosophy who say that it is the central purpose and morality of medicine to keep fighting for a patient's life, even when you have passed the recognised boundaries of experience and knowledge.

He says: 'If you mean by that, giving people a blood transfusion a few hours

before they die, I think it's disgusting.'

This view is completely in accord with Cochrane's tight, scientific mind and is not only a by-product of the bitter-sweet experience he had as a POW so many years ago. It is also part of his armoury against that part of the medical profession so wasteful in economic terms and in caring.

When Cochrane was freed, decorated with an MBE for his medical services to POWs, he started on what was to be his life's work as an epidemiologist. In 1946 he received a Rockefeller fellowship and spent a year in America studying the epidemiology of tuberculosis.

On his return he joined the Medical Research Council's Pneumoconiosis Research Unit. It was a move which was to catapult Cochrane into the forefront of his profession, thanks to his work in the Rhondda Valley where he and the research team had screened an entire community.

First attempt

He recalls: 'I knew very little about pneumoconiosis at the time. And you must remember that no one had attempted to X-ray an entire community before.

'We decided first of all that we must get a reproducible X-ray classification. Then we said that we must find out what the X-ray means in terms of pulmonary disability and life expectation.'

Although the massive screening study was primarily concerned with cases associated with mining diseases, it also included many other

physiological measurements of the community's health. One of the most amazing aspects of the study was that there was a 90 per cent take-up.

'The betting between my colleagues was that I would never get more than 50 per cent. But I drafted in two former miners who had the disease to work for me. They were very devoted people and did an excellent job in knocking at the doors and persuading people to be X-rayed.

'We would motor people down and after their X-ray I would sit with them and show them what it meant.'

Living in an idyllic three-generation household in Rhose near Cardiff, Cochrane has retained his links with the Rhondda. The first study took six months and he did a complete follow up in 1953. This year he hopes to publish the results of his 20-year follow up.

Productive era

The ten years after the initial survey were the most productive in his life. He helped put epidemiology on the map scientifically, by showing that one could geographically measure defined populations with about the same accuracy as laboratory measurements.

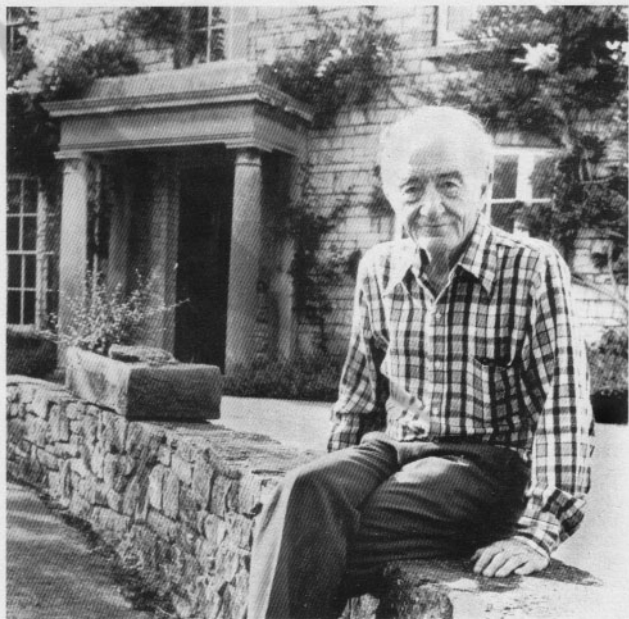
Although the most immediate results were in the world of coalminers' pneumoconiosis, there were marked repercussions in such diverse fields as the epidemiology of bronchitis, anaemia, rheumatoid arthritis and later health services research.

It was also at this time that Cochrane began to preach loudly and widely the gospel of randomised controlled testing (RCT) — as a result of his anger at what doctors were doing without the evidence of scientific justification, an anger that has become a lifetime crusade. He is convinced that there is no other way of inducing effectiveness into our practice of medicine.

'I've spent a lot of my life doing surveys and you have got to be careful that you do them on complete populations or random samples instead of biased opinions.

'You can only estimate the effect of a drug or therapy by giving it to some people and not to others.'

Such a crusade, while winning many admirers, has from time to time brought Cochrane into sharp conflict with the medical establishment over the ethical use of RCT in that people in a sample may die as a result of getting or not getting a drug or therapy that is



The present-day Cochrane has retained his links with the Rhondda, living still in his family home near Cardiff.

being tested. Incidentally, Cochrane believes that part of the opposition is also due to doctors defending their bastions of clinical freedom against the encroachment of science. But nevertheless Cochrane is sympathetic to the dilemma, although this awareness does nothing to offset his determination to ensure that RCT is a recognised and primary procedure.

To highlight the conflict he cites the case of a colleague, Dr H. Mather, who proposed that coronary care units should come under the examination of RCT. The proposal was that half of a sample suffering from acute heart disease should be treated in coronary care units, the other half at home.

'There was a fearful row and they set up a special ethical committee under Lord Platt which Mather and I attended. We won the argument.'

Cochrane is quick to add that he would never propose a trial that was harmful, although it must be said that it is difficult to share his sanguine approach if one lacks his scientific certainties; as do many doctors, not to mention patients.

There was an interesting postscript

to the row over coronary care units. Although London declared the sampling ethical Cardiff, for instance, did not. However, a test at Bristol showed that treatment at home was best for most patients.

Due to his belief, some would say obsession with RCT, Cochrane has also landed in hot water with the public at large over a lecture he gave in the sixties in which he said there was no evidence at that time that Pap smears led to a fall in the rate of cervical cancer.

Says Cochrane, rather ingenuously: 'For some reason there was absolute uproar. I got hordes of letters, some very unpleasant indeed. Also a lot of members of the profession wrote to me saying that I was killing people with cancer.'

'It was entirely unjustified. But that is of no consolation to you when even your friends desert you.'

It was during this time that Cochrane became a professor of chest diseases at Cardiff, a post he was to hold until 1969. It was not a very satisfactory time in his career. He was not a success either as a teacher or on

the senate, although he developed a bond with his students through his kindness.

But it did give him a breathing space to switch his research direction from field epidemiology to health services research and heralded a new lease of life for him in this decade, especially in the shape of a stunning monograph published by the Rock Carling Fellowship in 1971 entitled 'Effectiveness and efficiency; random reflections on health services'.

In a sense it sums up the man and his philosophy against waste and inefficiency in the health service. Apart from being a delight to read, it contains many essential truths which have fallen upon the world of medical sociology and epidemiology with no small impact.

Summing up

Perhaps it is best summed up by himself when he says at the end of the book: 'It is suggested that inflation (in the clinical sector of the NHS) could be controlled by science, in particular by the wide use of randomised controlled samples.

'It is hoped that by controlling inflation in the cure sector, enough money will be made available to deal with other black spots in the NHS, such as population control and the economic inequality between the cure and care sectors.'

Although the book was an instant success in terms of being read throughout the world, and most avidly by students who welcomed its brevity and wit, others were not so enthusiastic. One reviewer at the time said the book was limited and was potentially damaging and confusing in that 'rather than raising simply an attitudinal problem the monograph fails to distinguish biological from social phenomena. This leads to an assumption that experimental methods can be successfully and legitimately transplanted to social situations.'

Behind such criticisms lurks the continuing attack on Cochrane by his more conceptually based colleagues who say that he rides his epidemiology track with blinkers. But Cochrane shrugs his shoulders at this and admits disarmingly:

'I'm not of the conceptual school. The Nuffield is very keen on that . . . they always tell me I don't conceptualise enough.

'I get rather bored with it because I

‘If Cochrane has not found the ear of all academics . . . his thinking will find sympathy with administrators’

am not quite certain what they mean. I'm quite happy with myself as I am.'

He adds with just a hint of indignation: 'Its not that I don't have ideas, I have lots of them. But the difference is that having discussed them, I think to myself how can I test them?'

If Cochrane has not found the ear of all academics, not to mention doctors, much of his thinking will find a sympathetic response from administrators, a breed for whom Cochrane has a great respect having lectured to them on numerous occasions.

'I remember lecturing to administrators in Leeds and they said they were terribly depressed because they had set out to modify medical behaviour by trying to make the thing more efficient and had no effect at all.

'I think that it is partly snobbery in that doctors believe that administrators are stupid people and usually they are rather more intelligent than doctors.'

In this elitism by doctors Cochrane sees a very real block to the advancement of RCT findings being adopted in hospitals. For example he believes that far too many people are admitted to hospital and stay too long. He believes this to be economically inefficient and puts a lot of it down to so-called clinical freedom. As usual, he sees a solution in RCT and believes that it could help root out the problem.

Not only does he regard this as essential for waiting lists; but also in drugs; in wasteful technology which has not yet been tested but is costing the health service a fortune; and many other areas.

His message is: 'I think clinical freedom is a myth. Complete freedom would be anarchy and would be very bad for patients.

'Our duty is to give the best treatment. And if there are two equal treatments we must give the cheaper one. That can only be done by RCT.

'Now we have accepted that a democratically elected government should decide how much of the GNP

should be spent on health, we have a second duty to give the best value for money.'

But despite the doubts and the preaching Cochrane is optimistic. A widely travelled man, especially in the last few years, there is no greater advocate of the NHS than he when abroad. And it is not mere jingoism. He really does believe that the NHS, despite all its flaws, is without rival in the world.

Apart from universal acceptance of RCT, he sees our future in giving doctors a greater scientific training. He believes that his message is beginning to break through on efficiency, no doubt helped along by the current economic crisis.

As for his own profession, epidemiology, he is of course certain that its future is assured — but he has one worry. That is its poor recruitment rate. He believes this has happened in the wake of the junior doctors being paid for overtime they don't work.

He explains: 'It means that epidemiologists can't get that sort of money and we can't recruit them.'

As for Cochrane himself, he is still a busy man with many labours still uncompleted. He has just finished chairing a committee on backache and its report bears his own distinct hallmark. For it recommends among other things an RCT between doctors and osteopaths.

As one can imagine, the doctors were none too pleased at this latest piece of Cochrane mischief. But the old warrior has appeared before the General Medical Committee which has given him permission to go ahead. It could promise to be a lively time ahead for conventional medicine, thanks to the indefatigable Cochrane.

Judgement

How will posterity judge this man who has done so much to excite and enlighten the health service, come what may? The best judgement comes perhaps from another:

'He lived and died, a man who smoked too much, without the consolation of a wife, a religious belief or a merit award. But he didn't do so badly.'

No prizes for guessing the author of these fine words. It is Cochrane himself and it comes at the end of that obituary which one day will grace a local Welsh paper. It is to be hoped much later than sooner.