Portraits from Memory

21—Dr Eric Catford OBE (Mil) 1891-1982

JAMES HOWIE

In April 1941 I was suddenly transferred from 35 to 56 General Hospital RAMC, which was mobilised at Gillingham, Dorset, and all set for departure overseas. I

was warmly greeted by the commanding officer, Lieutenant Colonel Eric Catford, in civilian life a very successful and popular general practitioner in Torquay. He had served in the first world war and had continued in the Royal Army Medical Corps until 1923. Thus he was part of the regular army reserve of officers and so was mobilised on the outbreak of war in 1939. He had served in France but was now on his way to Ibadan in Nigeria. This information he

had somehow managed to collect although exact destinations of units were not supposed to be known even to their commanding officers.

Quick conversion

My arrival was made welcome. Had I been on a course of tropical medicine? No, I had not. The commanding officer of my previous unit thought that I had no need of such a course, having been a specialist microbiologist for nine years and on the Medical Research Council's list of approved specialists in laboratory medicine. This would have been good enough for most commanding officers of general hospitals but not for Colonel Catford. I must at once have some intense training in tropical pathology. The War Office was not enthusiastic. The unit might be on the move any day now; and this officer probably knew enough to cope. Not at all. He must have specialist training on tropical problems. So off I was sent with orders to spend a week at Horton Hospital with Mr P G Shute, a very superior laboratory technician and a real specialist in malaria.

In the event I spent exactly two hours with Mr Shute before receiving an order by telegram at once to rejoin my unit at Salisbury station and proceed to embarkation. But these two hours were priceless. Shute was not only a real expert with a great deal to teach me about malaria but such an enthusiast for his subject that in two hours he conveyed to me not only the latest laboratory tricks of the trade but his whole philosophy of malariology. It was only a matter

of time, he assured me correctly, before exoerythrocytic forms would be found for human malaria parasites. But what mattered to me, and to Colonel Catford, was that a new and enthusiastic recruit had just been created for malariology. In the event this proved more than a little useful to my new unit; but that is another story.

Old colonial style

On our way north to the Clyde by overnight train from Salisbury, Catford unrolled his papers and told his officers that he could now reveal that we were en route for Ibadan, Nigeria. He had found this out by his own methods and had thoroughly "cased the joint." Ibadan was in what was formerly known as the White Man's Grave; but we had all been immunised against yellow fever, and if we could control malaria we should probably survive. Moreover, unless the Vichy French helped the Germans to overrun north Africa, we might well find ourselves having only garrison duties to safeguard the airfields to keep open the transAfrican air route to Cairo and Karachi. We might therefore have a phase of the war in which our duty would be to keep up our morale without enemy action to stimulate us. In these circumstances our duty was not so likely to be ready to die for king and country as to avoid boredom. He knew what he was talking about. In the first world war he had served in France, in Alexandria, and in both Allenby campaigns in Palestine. He had twice been mentioned in despatches—no light honour.

Against the risks of isolation and boredom in Nigeria he had ascertained the names of leading citizens and officials in Ibadan, and it would be to our advantage to get on good terms with them in the old colonial style. This might well be on its way out—but not just yet. He had a very encouraging photograph of a society wedding in Ibadan, taken a month earlier. Clearly we could have a relatively civilised and comfortable place in which to do our duty.

So it proved. Catford at once called on all the local officials, paid his respects, signed their visitors' book, and invited them to dine in our mess. Tangible and intangible benefits accrued to our hospital with what seemed to be incredible good will. The mess itself was a happy and very well run affair thanks to the commanding officer's determination to have it so, and to his second in command's strong sense of reality and logistics. The second in command, "Jonah," was a South African radiologist, a bachelor of independent means, and a man who had learnt to play bridge for diamonds at the Kimberley Club. He knew Catford's enthusiasm for bridge and a comfortable mess, and he saw to it that every evening there were always officers "on duty" to see that "the old man got his game." Jonah himself played only occasionally and always as the colonel's partner. Even with the colonel's sometimes eccentric understanding of the losing trick count he and Jonah were never beaten. Jonah, however, was worried.

He had diagnosed the Colonel as a workaholic; and things could become too intense because there was not really enough genuine work to absorb his passionate desire to learn all the latest about all aspects of hospital medicine and surgery. He was resolved to absorb

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everything that his various specialists could teach him, and some very skilled and experienced surgeons, physicians, and other specialists spent periods in our hospital. From all of them Catford insisted on being brought up to date; and he was not only a willing but an able pupil.

"We've got to get him to relax for some hours of the day or he'll do himself and all of us in," said Jonah at an informal conference of the officers. We had all become honorary members of the Ibadan Recreation Club, but the colonel was only with difficulty persuaded to have a siesta from 2-4 pm and go to the club from 4-7 pm. Our day began at 6-7 am. Finally I offered to teach him golf in 30 minutes. He had played tennis, but never golf. But he bought six basic clubs and submitted himself to tuition. He quickly absorbed the idea of the straight left arm, the backhand blow, watching the back of the ball, and the slow and graceful swing; and he soon came to enjoy the game. It was a great relief to all concerned when the previous intensity for medical instruction was partly abated in favour of golf. He politely declined an offer from another officer to teach him snooker.

What a man

In looking after the best interests of his unit Catford spared no trouble. He entertained not only handsomely but with insight and discretion. One "very big master" was due to visit us. Who but Catford would have found out that he was not fit to talk to until he had downed two pink gins? But so it was; and the two pink gins were

ready and waiting; and the unit benefited enormously from the good will thus engendered.

It was a happy unit thanks to the energy, insight, and benevolence of a very fine man. Throughout his life he was a very loyal and active member of the Church of England. He was devoted to art, literature, and classical music. He said how much he loved the sound of a well trained male voice choir.

He was loved by his patients; he had a full and happy family life; and after serving in west Africa he went to the 1944 invasion of Europe in charge of the first field hospital crossing over on D + 3 day. He told me modestly that that part of his war was "quite exciting"—not at all like our time in Ibadan. He went on to become assistant director of medical services for the Normandy and later the Belgian-South Holland area, for which services he received the OBE (Mil). He was promoted to full colonel. On his 50th birthday, on the seventh hole at the Ibadan golf course, he stopped himself when about to play a shot and declared to me: "I'm 50 today; and I have this moment decided what I am to do with the rest of my life." He told me there and then that he would give up general practice and set up in Harley Street. I am confident that he would have done well; but his health and family considerations kept him in Torquay until, after the death of his wife, he retired to live with his daughter, Audrey, in Quidhampton near Salisbury. He lived to be 90. I met him three times after the war ended. He loved to reminisce about Ibadan, and about his days at Marlborough, Cambridge, and Barts; and the time was never long enough to exhaust his enthusiasm for the sheer joy of living and rejoicing in old friendships. What a man he was—and what a good doctor he must have been.

For Debate . . .

Efficiency savings or financial cuts: some morals from Birmingham

M J S LANGMAN

The impact of cash limits on the National Health Service (NHS) has been severe. Unexpected demands or underfunded pay or price rises put pressures on those limits. Health authorities, worried that overspending may put them in breach of the law, may resort to hasty and arbitrary cuts in services to patients. Unfortunately, cuts by one district can all too easily cause unexpected clinical demands on adjacent districts, which understandably have not budgeted for them, thus putting pressures on their cash limits. Birmingham has been suffering from this unwelcome phenomenon.

Each year the government decides in its autumn expenditure review how much money will be allocated to ministries for the next financial year. The sums allocated set the cash limits for those departments, and for the year 1987-8 the Department of Health and Social Security (DHSS) and the Welsh Office expect to receive over £18 billion for the NHS in England and Wales. Over £4 billion will be

spent on family practitioner services, which, incidentally, are not strictly cash limited like the hospital and community health services. Most of the remaining £14 billion is distributed through regional health authorities to district health authorities, which are responsible for providing hospital and community health services for their local populations, which range from under 100 000 to over 400 000.

Tight budgets mean leaner services

Large though these national sums are, by the time district health authorities and units receive their "cash limits," and even if they get extra funds for certain specialist activities such as organ transplantation, the money is often inadequate for the services that hospitals should be providing. Presumably the government expects tight budgets to make the NHS's restructured, accountable management run leaner and more efficient services, with the identification and elimination of wasteful practices. The efficiency savings then bridge the gap between cash limits and the cost of the service to the patients. That, at least, is the theory of introducing the stimulating environment of "commercial management" in the NHS. There are, however, at least three possible fallacies in this approach.