Portraits from Memory

24—Sir Graham Wilson, FRS (1895-1987)

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Even to those who worked closely with him, and who admired his work, Graham Wilson was an enigma with surprising variations. He was described by one close and loyal colleague as "reticent." I was asked if I thought that adjective too hard. My reply was that I thought it a great and generous understatement. When, in 1962, I proposed and promoted Graham Wilson for the LLD of Glasgow University, which I did with great pleasure, I found it extremely difficult to collect any of the kind of inside light hearted information required to prevent a promotion speech from resembling a premature obituary. It seemed that only two colleagues shared his inner thoughts: his personal secretary and protector, Miss Madeleine Barry, and his Medical Research Council colleague, Sir Landsborough Thomson, who had been closely concerned in the setting up and running first of the wartime Emergency Public Health Laboratory Service (EPHLS) and later, from 1946, of the permanent Public Health Laboratory Service (PHLS).

Close to the chest

There were understandable reasons for Wilson's reticence. Before the war of 1939-45, with his colleague Topley and with the active support of Wilson Jameson and others at the School of Hygiene and the Ministry of Health, Wilson played an important, although unobtrusive, part in planning the details of how the emergency wartime service should be administered and operated. As a result of various inherent difficulties in having such a service at all, the brilliant, and characteristically English, compromise emerged that the service would be administered by the Medical Research Council on behalf of the Ministry of Health. It is uncertain who first put forward this idea, but Wilson certainly regarded it as fundamental to the success of the enterprise, as indeed it was. In his view, nothing must be allowed to interfere with this arrangement. This prevented his saying anything that might put any other ideas in anyone's head.

While the emergency wartime service was being set up Wilson was at the Oxford Regional Laboratory. Topley, the obvious first choice as director of the service, chose instead to become secretary of the Agricultural Research Council. Dr W M Scott, of the Ministry of Health Laboratory, who was then designated to become director of the service, was killed along with his colleague Dr F Griffith during an air raid on London on the night of 16-17 April 1941. According to Landsborough Thomson there was a hurried consultation and a unanimous agreement to "send for Graham." So, for 23 years, Graham Wilson lived for the service and determined to preserve for it at all costs a freedom of strategy, tactics, and action which would allow it to provide an epidemiological microbiology service unique in efficiency and in freedom from "committee ridden bureaucracy."

To keep this efficiency and freedom intact Wilson would go to any lengths whatever. He had an admiration for and a loyalty to Topley's ideas and ideals which was one of his strong motivations. "What would Topley have done in this situation?" was one of his permanent questions; and his answer to the question—not always credible—was the guide to his behaviour. It was not a guide that could be systematised—let alone made public—even if it could be fully discerned. But it governed much of Wilson's thought and actions. He was never quite sure of what Topley would have done; and he was not quite sure what the DHSS might be thinking; and he often wished not to know.

Enough is enough

There were indeed many debates and doubts about setting up a permanent PHLS. Was it needed at all? Would not the specialist reference laboratories at Colindale be enough? Why must there be peripheral laboratories as an essential part of the service? These questions are still part of much current and ill considered argument. Wilson had no doubt, and I have no doubt, that joint laboratories in the periphery, sufficient in number to provide a reliable sample, were and still are and always will be essential. Microbiology is useless unless it is practised to an adequate standard, and systematic and continuous epidemiological investigation is impossible unless enough good microbiologists can regularly get together under expert leadership to plan joint working party investigations. The PHLS alone had the necessary arrangements to make this happen. It is unique and rightly admired at home and abroad. Anything that would cut the periphery off from the centre would be mindless sabotage. That was Wilson's philosophy—and it remains mine. We were completely in agreement.

Wilson secretly lived with the idea, which he never explicitly acknowledged, that the PHLS might one day take over all the microbiology of the National Health Service. This, as I thought, would certainly destroy the PHLS. Wilson acknowledged that the takeover would be resisted and "might take a long time." We debated it often, and I think he was disappointed in me for being prepared to accept merely an adequate sample. This was so

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important, as I thought, that I refused to endanger it by going for more. Peripheral information not adequate in quantity and quality would be useless; and it would never be secured without a loyal and integrated staff meeting regularly in committee.

No chance missed

Wilson told me often of various adventures that he had experienced in his efforts to extend the PHLS beyond the wishes of those who opposed the growth of joint hospital-PHLS microbiology laboratories. One account he gave me is worth recording as an illustration. He knew that a certain hospital laboratory had got itself into serious trouble as a result of grossly inadequate microbiology. He knew that proposals for a joint hospital-PHLS laboratory in that place would be resisted both by the senior administrative officer (SAMO) of the relevant regional hospital board (RHB) and by the local hospital pathologist. So—one Friday—he arrived by bicycle at the office of the SAMO and suggested a joint PHLS-hospital laboratory to avert any further substandard microbiology. The SAMO, relying on the known vigorous objections of the local hospital pathologist, was discouraging; but was incautious enough to agree that there *could* be a joint laboratory but for the objections of the local pathologist. If these could be overcome the regional hospital board of course would not oppose the idea.

This was enough for Wilson. He was at once “on his bike” and off to the local pathologist. To him Wilson conveyed cordial greetings,

sympathy over the recent misfortunes, and a proposal for a joint hospital-PHLS microbiology laboratory. The local pathologist, relying on the SAMO of the regional hospital board, said that the RHB would not bless the idea. But Wilson truthfully assured him that he had just checked with the SAMO of the RHB that there would be no objection on his part if the local pathologist did not dissent.

The local pathologist's nerve gave way. So the principle was agreed—details to be worked out after the PHLS representative had arrived to take his part. When would that be? Answer: “Monday morning.” And so it happened—fruitfully and in the end happily for all concerned. That was Wilson all over. No dishonesty—but no chance missed for extending the service—all in the public good. He was an incredible man. He was a perfectionist, scrupulously honest, but ruthless in the promotion of the PHLS. He worked all hours for his service. He spared no effort on its behalf—even if he did not realise that the change from the Medical Research Council's administration called for a new approach.

He worshipped Topley's memory, and in his editorship of Topley and Wilson's seventh edition of their famous textbook he has provided a double memorial for Topley and himself. He was a meticulously correct writer and an obstinately persistent editor. He was not an easy man to know—some would say impossible. He loved fine wine and good food. He was a very good gardener and a loyal and devoted member of the Church of England; and in all respects a truly English gentleman of unusual character and complete integrity.

Lesson of the Week

Osteolytic lesions in an elderly diabetic woman

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Haematogenous osteomyelitis is classically a disease of children but is being increasingly recognised in the elderly. Its incidence is bimodal, with the second peak occurring in the sixth decade.¹ In this older age group it usually affects the vertebral column: this accounted for over half of the cases in one series. The diagnosis is often missed in the elderly, osteolytic lesions being most often mistaken for malignant secondary lesions. Recognised risk factors include intravenous drug abuse,² diabetes mellitus,^{3,4} and urinary tract infection or instrumentation. The difficulty in diagnosis is emphasised in reports about the condition.^{2,3,5} It is an important diagnosis to miss, as it carries the risk of serious complications—for example, septicaemia, and paraplegia in spinal osteomyelitis.⁶

All patients with isolated osteolytic lesions whose cause is not known should have a biopsy

Case report

A 78 year old woman with a 12 year history of diabetes mellitus that was well controlled with insulin, who had been fit and active until seven months before referral, simultaneously developed pain in her left buttock and a urinary tract infection. *Escherichia coli* was cultured from the urine, and the infection was treated successfully with trimethoprim, but the pain in her buttock persisted and she was referred to hospital as an outpatient. Radiography of the pelvis showed an osteolytic lesion of the left inferior pubic ramus with a breach of the periosteum and associated specks of soft tissue calcification (fig 1). A bone scan showed a corresponding “hot spot” but no other abnormalities. The findings were interpreted as consistent with a neoplasm, most probably a secondary lesion, and the patient was advised to have a biopsy. She was initially unwilling, despite the diagnostic problem being explained, but agreed after about three months. While the biopsy was being arranged she was admitted as an emergency with septicaemia due to *Staphylococcus aureus*. She responded well to flucloxacillin and sodium fusidate, to which the organism was sensitive. Radiography of the pelvis showed new bone associated with the lesion, and this was considered so characteristic of osteomyelitis that biopsy was deferred.

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