

53. Joan Wilson

(1) Tell me about your background.

I was born in 1926 in a village in Cheshire, into a very loving, happy family. My mother was a mother at home, looked after us, and my grandmother was very well known in the village, and looked after the headmistress at the school who had taught my father, and all of us, really. I was. . . My father worked in the salt industry, because where I come from, in Cheshire, is where we get all our salt from now. I was, I suppose, quite bright at school, and got a scholarship to go to what I think is one of the best schools in the world, in Northwich: Sir John Deane's. And maths and languages were my forte, but for some reason, just before I was due to leave, I decided to become a nurse. It was during the war years, of course. And I went to a hospital outside Liverpool, because the Sister Tutor there had been moved from the hospital in Manchester, to which I really should have gone.

What did your family think about you becoming a nurse?

My father didn't want me to leave home at all, and my mother wanted me to go back to the sixth form and on to university, but said she knew that I would stick it out, whatever happened!

So, after your exams - School Certificate? - how much training was required for a nurse after that? How many years?

Three years, really, but because I was a bright spark, I suppose, I didn't even go for interview to the hospital. I went through the training school there, and went straight onto the wards, then, after six months in the training school. And just went on with the exams as they came along, and finally stayed at the hospital, where I'd trained, for a year after I'd got my state certificate. I was used as a staff nurse on the wards for a year before I got my state certificate, because I'd passed my school. . . my hospital exams a year earlier.

(2) What hospital was that?

It was the County Hospital at Whiston, where we had many, many beds; rather extended, because of the war. The training for nurses, then, of course, was preliminary training in school, to see you were safe to be sent onto the wards, and, from then on, we had lectures interspersed with our daily work on the wards. If we were on night duty, we had to get up early to go to lectures before we went on duty. And this went on during the whole of your training, until you finally took your state exam.

And what years were you training?

From '43 to '47, and then I stayed for a year helping on a gynae ward.

Did you come across any people with diabetes during your training?

I can only remember a girl on the children's ward, who had to be prevented from stealing sweets from her fellow patients.

Can you remember if you were taught about diabetes as part of your training?

Oh, yes, of course; yes. We were taught about all illnesses and how to care for them, and that was part of the examination at the end of the time. I took my final exam at Liverpool Royal Infirmary.

What was that like?

I don't think I minded it too much. I seemed to have been taking exams all my life, until then!

And can you remember what you were taught about diabetes?

I don't remember a great deal, because... except, of course, that they had special diets, some things were not allowed, and we had to measure carbohydrates. I was taught, of course, about the causes and the islets of Langerhans and insulin treatment, and not a great deal more during that time, really.

(3) You say you stayed on in the same hospital for a year. Then what did you do after that?

And then I went down to Kingston on Thames to start midwifery training, and stayed down there until '48, I suppose. And from there I went to the hospital in Lovely Lane in Warrington - Warrington General - where I completed my district midwifery. After that, the head of the county in Lancashire asked why I hadn't applied to take the health visitors' course, and would I get on with it. And from there, then, I went to Manchester, to UMIST, and completed the health visitors' course.

How long was that and what did it entail?

It was quite short and very intense. I remember we all had to address the audience, which made us all a bit shaky. We visited various places to do with general health, and hospitals with different specialties - which, I have to say, we had already covered in our general training - staying till quite late in the evenings, sometimes. And I travelled back to my family, twenty miles each day, from Manchester, and was able to live at home with my parents for that length of time, which was just over six months, I think.

Can you explain exactly what a health visitor was?

I had to make an application to the county medical officer of health, and I remember saying that I'd been trying to cope with people and their illnesses, and I wanted to try and keep people well. And the idea of a health visitor was to teach people how to live a better life, and how to care for their children, and therefore improve life in general, really.

So was it mainly concerned with children?

No, not always, because we followed up various other illnesses, like tuberculosis, which then was quite difficult to treat. And we covered quite a large spectrum, but the main thing, of course, was mums and children, and school children,

because we covered the whole spectrum of the children from birth to leaving school, in those days.

- (4) When I gained my health visitors' certificate, I was asked if I would mind going to Widnes. They were short of people there, and so I went as a health visitor in Widnes. And I remember I also took over a school for handicapped children that hadn't been covered by a nurse before, and a big comprehensive school, as well as the new babies and normal work of a health visitor. And I did that for about eighteen months. But then I came to Leicestershire and started to work in the City Health Department. In those days, the county was divided into County health visitors and City health visitors, quite separately.

What year did you come to Leicester?

The first of January 1952.

If it was 1952, then I'm surprised you were looking after a comprehensive school before that, because I didn't think they existed.

No, I suppose that's my idea, but really it was a large secondary modern school.

And then, moving to Leicester in 1952, what were your responsibilities then?

Well, I was given quite a large area, where there were a lot of problem families, and two schools, where I became quite popular, I have to say, in spite of the work we had to do. We did have a time when we had to go in and weigh and measure all the children each term, and, of course, we looked at feet and hair and everything else, so it had to be done in a very kindly way. And I coped with that, and the headmaster seemed to take to me quite well.

Were you just working in schools and people's homes?

Yes, mostly that was my job, but we did have liaison with the hospitals with some of the consultants, and spent time bringing messages back to the other health visitors about any people that were in their area.

Did you come across any diabetes during your time as a general health visitor?

Not anything that I remember being told about, because, of course, we didn't have so many people with diabetes in those days.

- (5) So, how did you become involved with diabetes?

It was Dr Joan Walker's idea that she would like patients to be visited at home, and taught how to live their lives at home. And she foresaw that the health visitors were the best people to be involved in this work. She already had been loaned a health visitor from the County, and our doctor in the City seemed to resist it for a little while, but then she was asked "could the City also participate in visiting diabetic patients at home?" And our large office of health visitors was asked for a volunteer. On Monday morning, the senior health visitor came to me and said "you didn't say you would do it, but you're going to"! And that

was how it all began for me, with Dr Joan Walker taking me home with her, teaching me all that she could about diabetes, loaning me books to take home. And fortunately I had quite a good husband to support me, and from then on I set up this service in the City.

What year did you become a diabetes health visitor?

That would be 1954.

Can you remember what your title was - the job title?

Yes, I was diabetic health visitor! Or health visitor for diabetes, which is more exact. But we were called diabetic health visitors by the GPs, and everybody that came across us.

And what hospital was Dr Joan Walker at?

Dr Joan Walker was at the Leicester Royal Infirmary. She had taken a slot that had been a medical clinic - outpatients - during the war, and was encouraged to start a diabetic clinic. Not always easy for her, because many of the other consultants - or, at least, she wasn't a consultant in those days, not until she almost retired - because of the resistance from the male doctors in the hospital.

What did you find out about Joan Walker and the diabetic service - what it was like before you arrived in 1954?

She already had a health visitor working in the County, who took me under her wing, just for a day or two. And she, herself, was a very gracious lady, very good to the patients. They had an annual review, in those days, and looked forward to it each year. She was very kindly, but very stern with the patients, and had quite a lot of opposition from medical consultants in the hospital, I hear, before all this began.

(6) So, describe your work in 1954.

Well, it was my duty to visit all new patients, and some of the elderly ones that didn't come to clinics so often, to teach them urine testing properly, and all about the care of their equipment, which, of course, in those days, they were glass syringes, which had to be wrapped in gauze and put into cold water and boiled once a week. And had to be kept in a covered container, then, containing pure spirit, surgical spirit. Many of them were found to be using methylated spirits, which wasn't allowed, and was greasy. Many of the syringes, I found, were morphia syringes, instead of being marked off in units for insulin, which made dosage difficult at times. And so that all had to be very gently changed. Cotton wool balls had to be baked in a tin in the oven to make sure they were sterile, and altogether it was quite a business. I remember with the children, many of the mothers hated the smell of this spirit in the house, which seemed to us to be the least of their worries.

What about urine testing? What did they have to do?

Oh, we had five drops of urine, ten drops of water and a Clinitest tablet dropped in it, which boiled. And patients had to be taught that if it turned orange and went brown, it was more than 2%, not less, and shown how to do that correctly. And some of the elderly ones, that weren't able to, saved a specimen for when I called, and I tested it then and helped them with that. We did work very closely with the district nursing sisters. Any new patients were notified to them. Because of the big area, it wasn't possible for one person like me to be there at the injection times, although if the nurses couldn't be got from the evening clinic, then I would go and supervise the injection. Sometimes, I have to say, I went over the border into the County, when things were bad and people were living a long way away, and there was no one to go the next morning. It also involved problem sorting. Anything to do with an upset life would upset the diabetes, and so we were able to help. I once went to

- (7) an updating for health visitors, and the person in charge thought we were wasted looking after people with diabetes, until I explained that we used all our skills that were taught us in health training: problem solving, helping with money worries, trouble in the family, and trying to make life easier for people with diabetes, as much as we possibly could.

How did you travel round to people's homes?

In those days, no cars were provided, and so I had two feet that took me all over the city. I had various lifts back in... when people felt sorry for me and helped me back into the town. I wouldn't dare to do it these days, but even a Lyons' Tea van gave me a lift one day!

Why did Dr Joan Walker want people treated in their own homes?

Being treated at home, of course, is where the patient has the meals that he's used to, where he uses the energy that he wouldn't be using sitting in a hospital bed. But also, there were so very few medical beds given over, in those days, for patients with diabetes, that it was very difficult, unless they were ketotic - that means very loaded with sugar and not being treated properly, or not diagnosed - that needed a hospital bed. They could go in as an emergency, but not routinely. And especially with the children was it so important that they got a small team round them, rather than lots of different people coming at them in hospital, and parents not knowing how they were going to cope at home at all. And so, if we were able to go in, as we had to the very next day with a child, we could help the Mum with diet, even if it was just for that day, and listen to their problems, and help them, with the rest of the family, to cope with this new emergency.

What do you mean by people coming at them in the hospital?

Lots of different people coming to give the injections, and strange surroundings; very intimidating for a child.

- (8) I didn't explain that not only did I work with Dr Walker, but with all the other consultants, and, especially in later years, closely with the paediatricians. And one child was taken in - Mum was expecting a new

baby; a good family. This dear little thing was on the ward in the hospital, and I went to see her. And the parents were standing up against the wall, and the little girl was with them. And when I spoke to the paediatrician, he said “really, she could go home, Joan, but it’s Saturday”. And I said “send her home, and I’ll go in in the morning from home”, because, although hours were supposedly nine to five, they never really were with us, because we worked from home. Patients had the home telephone number. We tried to restrict the calls to between eight and nine thirty in the mornings, but emergencies came through at any time. And the consultants could ring with new patients at any time, and knew that we would drop what we were doing and go immediately, especially to the children.

Some of the patients I’ve talked to, in the early 1950s were admitted to hospital for, you know, two or three weeks. Did that not happen with Dr Joan Walker?

I think after we arrived, it wouldn’t be quite so long, but patients were admitted sometimes undiagnosed. I’m not sure about children in 1954. I would imagine that... they were treated at home, unless they were in ketoacidosis, which means that, you know, they had had no treatment and the sugar was very high, and their...

(9) So, even in the early 1950s, Joan Walker was just admitting them for a very short time and treating them in their homes?

Yes. We would try not to keep them in hospital for very long, because that’s not a normal situation, unless they were really very ill, of course, and then there was no question about them being cared for there. But to treat them at home, where they were using their energy in normal amounts, and mother could work out the diet and get used to it at home, things worked out very much better in the long run, after the shock of the first diagnosis.

Was there a lot of shock?

Yes. Most Mums found it absolutely dreadful to be confronted with all these regulations. It had to be done very gently, really; a stage at a time. And because we were able to go as much as we were needed, even to the point of helping with the injections when they were found to be difficult, it did help in the long run. And I’ve had quite a few children who have gone to university, and proved to be really very good, with Auntie Joan in the background!

When you talk about “all these regulations”, what are you referring to?

The thing that hit the family most was this business of the meals. They were very severe to begin with. Every bit of carbohydrate seemed to have to be counted, and gradually that was made much easier. It was explained that, you know, an apple, perhaps, is ten grams of sugar, but it’s not the same sugar as the sugar made from flour, and things like that. And where the interchanges were given to the mother on a card - this is equals a round of bread, and things to have when the child’s sugar got too low - there was a lot to take in. It really

did take time, and they needed to be able to trust you, and know that you would be there for them when things went wrong.

(10) What else can you remember about the diet?

I remember having to learn about equal amounts of ten grams of carbohydrate. And patients were given so many grams of carbohydrates through the day, spaced out properly with a snack in between if they were on insulin, or reducing diets if they were overweight and trying to lose weight, and on, probably, tablets rather than insulin, or even diet alone to begin with. And so, mothers got very confused with diets, and they were worrying about one gram of carbohydrate short, and what should they do to make that up. And none of that, really, was as important as it seemed to them. The diets became very much better when it was realised - I think it was research done in Oxford that said, you know, an apple may give you fruit sugar, but it's not the same as the carbohydrate from bread. And so, when we were giving all these interchanges - even a pack of cards with ten gram exchanges on them with pictures of different things - it really wasn't altogether true, I suppose. And when diets became more flexible, and it was realised, you know, that children use more energy at certain times of the day, and needed extra things for games. We didn't like the children being excluded from anything at all at school. And we did go into school, initially, with every new child, and we also wrote a report to the school Medical Officer of Health for that school, so that there was liaison there. We also, very importantly, were the liaison with the GPs, which the GPs hadn't had. Even the awkward ones finally gave you more patients to visit when you managed to get through the door! And so, we became well known and trusted. And that was the main thing: to be trusted by the patients and by the doctors alike. And eventually it became that we were helping with all the consultants who had diabetics in their specialty, which were seen by them at their clinic.

So, they might have had something else completely wrong with them?

Yes. They would be going for a different reason, and the diabetes would be secondary, and very often needed help, really. And so, one of us was always available, on a rota basis, at the clinic days. We worked out our own clinics and we advised patients in the clinic. They knew when we were there and they could come, and eventually that service grew as time went on.

(11) Were you attending diabetic clinics in the Royal Infirmary from 1954?

Yes, that was part of the job. We had a Tuesday evening clinic for workers, we had a Saturday morning clinic for children to be seen first, and then other people who couldn't come on the other days - Monday afternoon or Wednesday morning. And so we attended all of those clinics on a rota basis, which we worked out ourselves at the beginning of each month.

And were there ordinary nurses at these clinics as well?

Yes. There was a sister in charge of outpatients, and nurses working with her, testing the urines and so on, ready for the consultant. Eventually we had our

own rooms, where we could teach and have tapes and group meetings, and things went on apace from that.

So, how was the role of health visitor different from the role of the nurses at the clinic?

Well, the health visitor was there in an advisory capacity and a teaching capacity, and also able to report anything to the consultant or to ask his advice. We did have his phone number, of course - we weren't just let loose in the community without any backup at all. If there was a problem, then we knew we could speak to the consultant about it.

What was the seniority between health visitors and nurses?

Well, at first, they wondered who we were! And there was one in the County and one in the City, of course, and it was our job to get on with them, and we did. Changing over was different... was difficult. I was supposedly there for a year, and I did fifteen months until we got someone else involved, who I was able to take around. And by that time, a car was provided for the diabetic health visitor. And so, we had a little handover time there. But really, changing over wasn't a good idea, because the longer you worked there, the more you learnt and the more you were able to pass on. It was something, really, that I found you needed to be in all the time. It was quite a hectic lifestyle, but very rewarding too, because you were really helping people to get on with their lives, and trying to make life easier for them, and keep them up to date with all the new equipment. And then we had a big changeover to U100, when the insulins all became one strength, instead of the three that we'd been using for years.

What was the changeover like?

- (12) The changeover was amazing, because people thought that the insulin was going to be so different, and things were going to be bad. And it was hard to convince some of them that, instead of dividing their dose by two or four, according to what strength they were on, and giving those marks in a syringe, they just had the number of units they were prescribed. We had a few hiccups with the ones who didn't take that on board very easily. There were quite a lot of evening meetings, quite a number of GPs had patients who didn't want to come to the hospital to be changed over, and so I was involved in that too.

I've become slightly confused by the phrase "changeover", because we've had the changeover from the insulins... Yes, what was the other earlier changeover you referred to?

The changeover was the business of just having a health visitor seconded for one year, because the continuity wasn't there. And all the things we learnt about caring for people with diabetes grew year by year, and you became able to cope with many things that weren't your remit, originally.

Was it just diet and insulin that you were interested in?



No. Feet were important, exercise was important, especially for the children. It was getting them involved in games and everything else, and school trips, and so on. And there were some holiday camps for diabetic children in the early days. We also had some beds at Burley on the Hill, out in Rutland, where we had a wonderful matron in charge and patients could go for convalescence - diabetic patients, that is, apart from the others who were there. And also then we had great help from doctors in Nottinghamshire. We had a convalescent home there, and we were able to send people for extra teaching there, and to be kept under a wing of nurses who were specially trained in diabetes, who did a very good job. I think that was a great help to us. That has all gone now, of course, but more's the pity.

- (13) We've talked mainly about your memories of children and their mums in the 1950s. Tell me a bit more of your memories of older patients.

The older patients needed help, really, from the district nurses, and from me, to be able to cope with new things coming along: new ideas in diet, the testing of urines, because originally we had to boil two lots up with Fehling's. I don't think patients ever did that at home. But when the Clinitest came along, they were hopefully able to cope with that. The ones who couldn't were visited by us on a fairly regular basis, at an appointed time, when they would save a specimen. And we helped them with other things. We were very keen, of course, on care of the feet, because that's where problems start, and...

What did you do in terms of care of the feet?

Well, we asked them to wash them regularly each day. I think, originally, they were asked to put a tiny bit of salt into the water. I think that was just to make it seem special, because I think we proved eventually that it didn't make a lot of difference. But to dry well between the toes, and not to rub hard and not to cut corners. We had a chiropodist attached to the clinic, and also, later on, we were able to refer our patients with diabetes for chiropody in the County... in the community. That was something we did on a routine basis. We did regularly visit elderly patients, and when I talk about diabetes, I say that, now that I've retired, I miss my children, and I miss my elderly. The ones in between, we tried to make independent, to get on with what they were doing. If there was a need to go into the place of work, then we would do that, and try and smooth things over. We were always there in the background. And some came regularly, when they knew we were at the clinic: "Hello, it's only me. I just want to ask you this...". And so, I still hear, occasionally, from some of them now. They coped - they didn't think they were ever going to - and they've lived to ripe old ages, and proved lots of things wrong.

What do you mean by "going into the workplace and smoothing things over"?

Well, of course, there was always this business of people on insulin may have hypoglycaemic attacks. This had to be mentioned, of course. It had to be mentioned in schools and in workplaces, if the person couldn't cope himself. We never interfered if it was going to make a difference to them. Some occupations,

of course, were dangerous for them, and sadly that had to be changed. Drivers of heavy vehicles lost their driving licences, which was always very sad. But other things usually came along, and made life a little bit easier for them.

- (14) We tried to make sure that there was glucose available, for if anyone seemed to be acting a bit peculiar, or going faint, or shaky, or sweaty, or some of the signs of sugar going too low, that someone in the works would know how to cope with it. And trying to help allay their fears about things. School was important, of course, because often the teachers thought they could cope, and then, when something came along... I remember buying a box of glucose, more than once, and taking it into school, and saying "if this child shows any of these signs" - and the card was left. It wasn't all done by word of mouth, there were instructions left too - "Just give some of this. It won't do any harm, but it probably will be the thing she needs". But when this did happen, the child was put in a taxi to go home, without any help at all, even though the headmaster had told me he knew how to cope with diabetes. So, we were useful sometimes.

What years did you give up work to have... look after your children?

My son was born in 1958, and so, in June '58, I retired. And I stayed at home for seven years, during which time I had my daughter in 1960. Then, in '65, having been persuaded, I returned to general health visiting. And then, when I applied to go to work in the County - for we were still, then, two separate authorities - my senior heard of what I was doing, and was determined that I shouldn't leave the City. I was offered the choice of children with hearing difficulties or the diabetic clinic, where they were anxious to have someone back. And back I went to the Royal Infirmary. Fortunately for me, that summer, Dr John Hearnshaw - who had taken over at Dr Joan Walker's retirement - had a sabbatical and went to America. And Dr Walker came for six months when I went back, and I was gently taken back under her wing, and told to get on with it. And from then on, I stayed for twenty one years.

- (15) Can you just clarify, then, when you were a general health visitor and when you were a specialist diabetes health visitor?

From the beginning?

Yes.

From the beginning. I came to Leicester in January 1952, and began as a diabetic liaison health visitor in 1954, with Dr Joan Walker at the Leicester Royal Infirmary. That was supposed to be for a year, but I in fact stayed for fifteen months. And then, the changeover to another health visitor - Dorrie Baxter took over from me - and I went back to general health visiting, thinking it was time I started a family. And in 1958 I retired, and my son was born later that year.

And then, when you went back in 1965, were you a general health visitor?

Yes, I went back to general health visiting, having been away for that time. I was given a huge problem family area. I didn't have a car, found it very hard going, because we were following up lots of different things in the community. And then I was persuaded to go back to the Royal Infirmary to be a continuous health visitor for diabetes, and that was what I chose to do in 1970.

And that was when Joan Walker was with you for six months?

Yes. Joan Walker came to take over the clinic for six months while Dr John Hearnshaw - who'd taken over from her on her retirement - had a sabbatical and went over to America. Dr Joan Walker had been in America, and lectured over there, and so she was fairly well known amongst the medical fraternity over there. And, I suppose, Dr Hearnshaw was quite well received. She was there for six months whilst I was there, and I was able to get back into the routine quite easily; in the clinics, doing the same work that we'd done before.

(16) Before we move on to your work from 1970, have you got any other memories from the earlier years?

I have a very strong memory of a horrible Cyclemaster that I was expected to ride. I was asked, by Dr Walker, to accept it. It had been offered from the health department to help getting round this big city area that we had, and the work was becoming more intense as the time went by. And so, this Cyclemaster was a gruesome thing. I remember going to the ambulance station to collect it. And the man said "can you ride a bike?", and I said "yes" - I'd delivered babies riding a bike, almost. And I got on the wretched thing, and it was shocking, really, because we had lots of times with it when the petrol lead jammed and it wouldn't stop. And I remember a policeman standing watching me as I stood looking at it, wondering whether I ought to get on it again. But eventually, with very pale L-plates on it, I rode it all over Leicester city.

When was this?

In the 19... 1955, I would think; the end of '54 and '55. And I did get around, but if it had been raining, my legs and feet were splashed up. And I did visit all kinds of patients - some of them were private patients, I have to say - and I had to clean my shoes before I went to the door! But it got me around, and finally, it was the thin end of the wedge, and the next person to follow me did get a car.

You mentioned private patients: whose were these?

Well, they did belong to the consultants. And there were just a few that we visited, by request, to help with diet and general care, and sort their lifestyle out a bit.

When was this?

This was... it would probably be after the... in the 1980s, I would say. We didn't get any extra pay for that, at all. We visited anyone with diabetes who needed our help.

Now, you say you were attached to the diabetic clinic at Leicester Royal Infirmary from 1970 until you retired in 1991. Can you remember what the titles of your jobs were, during that time?

Well, we were diabetic health visitor, specialist diabetes health visitor, diabetes liaison officer and diabetes specialist nurse. To begin with, we were on the payroll of the City Health Department, but then our senior officer decided that really, we were at the Royal Infirmary, and we should be on their payroll. And, I believe in the 1980s, we were transferred to the payroll at the Royal Infirmary.

Whether you were called a health visitor or a diabetes specialist nurse, was the work you were doing essentially the same from 1970 to 1991?

Yes, there was no change. Whatever they called us, we still did the same things. We still were in the clinics, advising and teaching, and visiting at home for the rest of the time.

- (17) I think it must have been in the '80s when the City and the County became one health authority. And so, we were all then zoned, so that we had part of the County and part of the City. And there were more of us. I think some were doing... one or two were doing part-time, but mostly there was a full-time health visitor in each area. And we ran clinics in the County too, so that people didn't all have to come to Leicester Royal Infirmary. The consultant went out into the County, and we were there to help in the clinic, and teach the nurses and the patients, just as we had been doing at the Royal Infirmary.

Where were these clinics?

Hinckley, Market Harborough, Loughborough, Melton, Oakham. I think that about covers it. Sometimes, also, we were asked to help when GPs were asked to set up their own diabetic clinics. We certainly were asked to help to teach their nurses how to run the clinics. We got a little bit concerned - well, more than a bit concerned - because we didn't feel that complications would be picked up so quickly as they were in the clinics, where we were then doing eye photography, and being very keen about circulatory problems, and so on.

Were you doing eye photography in these little clinics, in the small towns you mentioned, or just at Leicester?

Because of shortage of people to use the cameras, the eye photography was really just based, to begin with, on the Royal Infirmary. I don't know if anything has changed now.

Were you right to be worried that complications might not be picked up by GPs?

Yes, especially blindness, really. We didn't have so many amputations, since we were teaching people more thoroughly, and that was a blessing, for there were some dreadful feet in those early days. Pictures that one would never forget. Fortunately, that isn't happening quite so badly now. But yes, we were concerned, and I think there is still cause for concern in some areas, even now.

When you talk about bad feet in the early days, are you now harking back to the 1950s?

Yes. It was in the 1950s when the circulatory problems had done lots of damage, and there was bit surgery done on toes and feet in those days. That - because of better control and better knowledge, and patients more receptive of advice - things have moved on. And it is just eyes would worry me now, just the same, because I feel many patients came to us when the damage was found behind the eyes, and it was too bad for us to halt the damage. And blindness is still one of the real problems with people with diabetes.

(18) So, jumping forward, again, to the 1980s, when you were setting up these clinics in outposts, as it were. Tell me more about those clinics.

Well, the clinics were to save people travelling into Leicester to the Royal Infirmary. And also, of course, the clinics at the Royal were getting to be so much bigger that it was easier for patients to be seen in the smaller hospitals. And so, fortunately, we were able, with the help of the consultants - we then had two senior consultants, because Dr Felix Burden had come to join us, and kept us all up to date very well - and we ran clinics in... I didn't mention Coalville, but we did have a clinic in Coalville, which we did in a health centre, to begin with. So, we were responsible for everything: the bloods, the urine testing, everything. Keeping the doctors going with a cup of tea, because they'd all come from clinics in the main hospitals in Leicester. And teaching patients; and we gradually started teaching sessions separately, when we had one afternoon or one morning a week when we invited patients to come and discuss the diabetes. We had a series of talks covering everything to do with diabetes, with a different topic each month. And then patients were able to ask their questions. And we got... even the ones who found it difficult to cope with came along, and talked to other people, and watched our programmes on the television screen, and discussed their problems with us - some of them quite personal problems, which they were able to come to in con... to us about. And it did grow from there. We did teach everything to do with diabetes - that I can think of, anyway. And they were much appreciated, and very well attended. Even the young teenagers that we hadn't been able to get to sometimes, did turn up with their questions, and usually quite enjoyed themselves. We also... I was involved in a bit of research they were doing at the Royal - well, not a bit, really, it was important research - into islet cell transplants. And I had a good team in Hinckley, where I had a group of children and parents, and we raised money for funds to help with that research. I was able to have permission to take them round to show them the unit where the research was carried out. We used some money we had, from various charities, to buy blood monitoring meters for the children, so that we were able to let them have a meter themselves. And from that, I think, control became quite a lot better with something technical that the children could use themselves. And they went on, eventually, to buy their own better ones, as the smaller ones came along, and were quite grateful for that help.

(19) You mentioned that Dr Felix Burden kept you well up to date. Can you

remember what kind of things he kept you up to date with?

Yes, he... all the new ideas about how to give the injections to make them painless. I used to inject myself, really, in front of the patients, if they were squeamish. I can't say I enjoyed it, but I never pulled a face so that they didn't think it was anything terrible either, and managed to persuade people to do their own injections. I had only one man, I can remember, who wasn't going to ever go onto insulin, and I thought that was going to be my failure. But I found out one or two bits about him, and, when I explained what might happen, he decided that perhaps insulin would be good for him after all, and I had no more trouble.

What other things did Dr Burden teach you?

He was... kept us up to date with lots of things, and also he did a lot of research, which we were able to join in with, especially one of my colleagues, who had a big area with Asian patients. There was a lot of research done into their dietary habits, and the way they use so much ghee in their cooking, and all have so much weight to carry around with them. And we learnt how to cope with the Asians, I think, probably with help from him. And we had... all the different languages were available for all the diets they were on; they were always kept handy at the Royal Infirmary. And we learnt a lot of their customs, and some of them joined our Diabetic Association. We were kept on the map, by Dr Burden, quite a lot. He was always popping up here and there, writing articles about things, and the... I was able to get on very well with him, as I did with Dr Hearnshaw.

It was a big change in the population of Leicester, with more people coming in from outside. How did that affect you?

The clinics became enormous. When the Ugandan Asians came over, they all seemed to turn up at the diabetic clinic, and so we learnt to cope with them. Some of them were wonderful people, really. We had one man who was treasurer of our Leicester Diabetic Association branch, and he was a lovely man, who nothing was too much trouble. And I have to say, the Asians did raise quite a lot of money for research.

(20) You say "our" local association. Were you involved in the British Diabetic Association?

Yes, I became chairman of the Leicester branch for some years, and helped out once or twice after I'd resigned. It's still going strong. And they still have meetings, monthly, and outings for the elderly, which we used to have in those early days with Dr Walker, when we gave them a Christmas party in the canteen at the Royal Infirmary. And we had quite a few well-known people, in the diabetes world, come to visit us here in Leicester. We also had people... I had people from Australia and New Zealand and Sweden who came, and I took them out with me to show what work we did. And they went off back home, and said they were going to try and start systems in their own countries in the same way.

What effect do you think the British Diabetic Association had on the care of people with diabetes in Leicester?

I think the Diabetic Association was a caring group. I think patients who thought they weren't being treated fairly were able to come along with their problems. They also were very keen to help raise money for research, and that's still ongoing now. It was a community. They were all very fond of Dr Walker; there was, I think, nothing they wouldn't do for her, really. And when I started back diabetic health visiting, and I had someone who was perhaps a bit awkward, I used to say "well, this is what Dr Walker would tell you to do", and immediately it was taken on board.

(21) You've mostly talked about improvements in the care of people with diabetes. Do you have any memories of things that went wrong?

Yes. I can remember a man coming to an evening clinic at the Royal Infirmary, and the consultant, or the registrar, couldn't really see what was going wrong. And so I asked him to bring his bottles of insulin to me, which he did. And in those days, we had three strengths of insulin: twenty units to the ml - usually for children, forty units to the ml, and eighty units to the ml. If you were on forty, you divided your dose by two. If you were on eighty, you divided your dose by four. I didn't find that difficult, because my special subject, really, at school was maths. But it was very confusing to some of these; more confusing, since this man had been discharged from another hospital with two bottles of insulin to mix. Usually, if you had a quick-acting insulin, and you wanted a longer cloudy insulin to take over when the quick-acting finished, you had to mix two kinds of insulin. This man was having two lots of insulin from two separate bottles. They were both quick-acting insulin - one forty and one eighty strength, so he'd been given the wrong insulin. So, that solved that problem. One man, I didn't seem to be making any inroads to. It was a fairly poor household, but trying hard. And I said to this man "now, we've increased your insulin by four units - by one mark - on your syringe, but we're not getting anywhere". And he kept his syringe and insulin upstairs, and I said "bring down your syringe and your insulin and show me what you're doing". And it just shows how you can be misinterpreted: "Put another mark on your insulin" meant to him "push the plunger up", so he was having less every time instead of more. So, that was another time when things weren't going very well. Two other things that happened, really by the grace of God, I would think. One old lady had been discharged from hospital the day before, and I happened to think that, although she was just on tablets, for some reason I ought to just pop in and see her. And for some reason, also, I asked where were her tablets that she'd been prescribed. And when I picked up the bottle - she was on Chlorpropamide, which was a fairly longish-acting tablet to jiggle up the glands to make them make more insulin. What she had got was Chlorpromazine, which was a sort of sedative narcotic thing, which, if she'd had the dose of that that she was on of the other tablets, she would have been out cold, I think. So, off I went to the chemist and asked them to produce the prescription, and it had been misinterpreted by the

chemist. So, that was a little bit of a thing we put right. The other thing was one lunchtime, when I was a bit hungry and I'd been on the other side of the town, and I'd had this dreadful Cyclemaster. But, for some reason, I went to see a patient called Betsy, who was quite a pet of Dr Joan Walker - she was a very simple soul. And when I got there, I couldn't get in for a bit, and then I managed to get in, and she was completely out, lying on the settee. And the story was that she'd gone to the post office to get her pension, and she'd felt a bit giddy and a bit funny, and they'd just said "go home, Betsy, and lie down", which she'd done and gone unconscious. So, I had to go into the factory next door and ring for an ambulance and get her into the hospital, and we were able to resurrect her. So, that was, I think, the hand of God that day.

(22) And still on this question of whether things have improved. Do you see diabetes care as just a story of improvement?

I have to say I do, really, because the disposable syringes came along, and that was a great help. And then, of course, these... the pens that are loaded with the dose, and are so easy for patients to carry around and administer at any time that's necessary. I think that is much better. And there's much more known about it now, of course. It's more widespread, we've got so many, many more patients with diabetes. And the nursing staff has increased, I'm sure, over the years. There are many more people involved, now, in diabetes care. And while we were plodding on in those years, we were also training nurses, or had training sessions for nurses and for district nurses. And I tried to keep the district nurses up to date, all the time, with all the new equipment that was available; going to them and teaching them. And speaking to nurses in training about diabetes, and doctors, sometimes, when I was invited, and telling them about the things that were available. And yes, things are very much better. I mean, we have quick treatment for hypoglycaemia, which came out in various ways early on. And now patients are able... I mean, first of all we had Glucagon, which came from America, which injected can raise the blood sugar temporarily, in time for you to feed a patient, whose sugar's gone too low, with sugar by mouth. And we had HypoStop, which we would put inside the cheeks of a patient and massage gently, and that would start to be absorbed, and would help to bring someone out of an insulin coma. I think aftercare has improved. There's lots more known about it, more people are interested in it, and, although it is increasing, people are able to cope much better. Their lifestyle's easier, they're given much more freedom, it's not so rigid. The diet is not so harsh, and they're taught how to cope with their own insulin doses, which is so important and makes them independent. A diabetic patient taught properly will know better how to look after their own insulin dosage than people who are not involved with diabetes care. But maybe the individual attention isn't there, quite so much, now. We were very well known to the families, and, amazingly, I used to be rung about the rest of the family, and what their spots would be. It was amazing how we were involved with people, after they got to know and trust us. I had even been out at three o'clock in the morning, where I had a very anxious mother and a child in hypoglycaemia. And it was worth showing how to deal with it at that



stage, and from then on, things could only get better. And that child is now grown up, married man, went to Birmingham University, and is making his way in the world very well and truly.

(23) How did you find the time for this level of individual care?

It was very difficult. It was quite hard going, I have to say. I did enjoy it, but I did become exhausted too. And I did have to draw the line when my family found it difficult to cope with, and so I managed to have one day off a week, which eased things a little, and meant I could collect my senses. That didn't always work out, but at least I knew that there was going to be a time when I could catch up on things. There was a lot of out-of-hours work, and a lot of late visiting. And, of course, as I've told you, we did work from home, and so the phone suddenly became more for me than for my husband, and he learnt to cope with that. We had quite amazing conversations about people ringing when I had gone off to do my visits, and someone would say "what do you think she would tell me to do?". And one lady said "I've got my daughter here, and she's not... doesn't seem so well, and I don't know what to give her, and what do you think I should do? I think, perhaps, I'll send for the ambulance". And he said "I think that would be a very good idea"!

So, that was your husband giving advice.

Yes. And people used to ring up. And I said to Dr Hearnshaw, one day, "my husband answers the phone, and they say" is that Mrs Wilson?", and he says "does it sound like Mrs Wilson?" " , and John Hearnshaw said "well, he is a comedian, after all"!

What other advantages do you think there were of home visiting?

Home visiting was important to me, because that's where you saw how the family lived, what you could expect them to do, for it was no use asking them to do things that were beyond their remit, or something that they couldn't possibly cope with. It was no use writing out a diet that they wouldn't be able to stick to. You had to analyse their own eating habits and what they would have, and tell them which quantities would be right at each meal. And also, you could assess problems and troubles in the home, which came to the surface when you could see distress. You don't see that in a clinic. People cover up things in a clinic, even to the point of bringing tap water in the urine specimen, or somebody else's specimen at the time, which has happened. And the cheating the children used to try to do in their books. All those things came to light. When they knew you, they would tell you about it, and you were able to help and encourage them. The most important thing was to encourage them, and to be a friend, but still professional with it.