55. Dr Ali Zafar=

(1) Tell me about your background.

Well, I come from India, and I was born there and brought up there. I did my primary school, college and medical school all in India. I come from a family, basically, of lawyers. My grandfather was a lawyer, my father and uncle was a lawyer, but then we were six brothers, and none of us went into law after that. You know, there's one more doctor... or was a doctor in the family, and I'm the second one in that group of... pack of six. After qualifying in 1967, I did some house jobs over there, and then came over to UK in 1970; beginning of 1970. So, I've been here a number of years.

Well, first of all we'll cover your time in India, before moving over to the UK. What sort of schooling did you have?

Well, I went to a local school, and this was what you call an English high school, so... But we... although the medium of instruction was English, we had to study other languages - local languages, national languages - and then science subjects. So, you know, it was a fairly average public school, really.

And what took you into medicine?

Not a lot of thought, initially. It was supposed to be a sort of stable profession, a good profession, where you served a lot of people, and it had a lot of opening in terms of job opportunities in India and abroad. So, with that in mind, plus one of my brother was already doing medicine, was already qualified by that time, so he encouraged me to go into it, and I decided to follow suit.

And where did you train?

Again, I trained in India, in a medical school in Bihar State, and qualified 1967. So, it was a five years course, plus the house jobs, et cetera, et cetera.

Had you encountered any diabetes before you began your training?

You mean in the medical school itself?

No, I meant in your family, or...

No, we have been very fortunate. We have got no history of diabetes in the family, or at least nothing diagnosed. My parents lived to ripe old age, and I'm not aware of any diabetes there, either in them or in my sibs.

Can you remember, at all, what your image of diabetes was, if you had any image at all, before you began training?

Well, my own impression was that, you know, you were not allowed sweets and sugars, and things like that. But, more than that, really, I wasn't aware of any complications or long-term impact on lifestyle, etcetera, etcetera, at that stage.

What do you remember of first encountering diabetes during your training, and what year would that have been?

I think, if I remember correctly, it will be about 1963, '64, and we had this patient - this person - who was admitted into hospital for being started on insulin. It was a big thing to start on insulin in those days, and my consultant decided to bring him in. I think he was a retired judge, or something. And that was a big thing, in those days. Everybody, virtually, from my class came to see this particular person.

And can you remember what form the treatment took?

Yes, it was twice daily injections, in those days, with some monitoring of blood sugar, but we didn't have any sticks to monitor blood. And, basically, I had to send bloods in the lab, and get the results several days later, to find out what the blood sugar levels were. But, I seem to remember that this man was pretty unwell. He had neuropathy, he couldn't walk very well, so this may be the reason why my consultant decided to put him on insulin.

(2) Can you remember how much you were taught about diabetes during your training?

Difficult one; I have to go back a lot of years. I don't think it was taught all that well, or in that detail. I'm just looking back. Maybe, perhaps, we didn't have such a high incidence of diabetes in the community, at that particular time. So, I would say it was just one of these subjects that was covered, but not particularly emphasised upon. We had much more to do with TB and malaria, and things which were prevalent in my part of the world, than diabetes, which was not a particularly fashionable disease, at that time.

And can you remember the attitude of patients to diabetes?

As I said, my encounters were not all that many before I came here, and I think most people were resigned to the fact that they cannot eat certain kind of food, and they will have to take either tablets or injections. But, it was also, from what I remember, a lot of people didn't want to talk about their diabetes; they wanted to hide the fact. And, in fact, I find that even now, in particular Asian community in this country, that they don't want to talk about diabetes, and they want to keep it under wraps. So, there wasn't a stigma attached to it, from what I understand, but still people were reluctant to talk about their illness.

Why?

I don't really know. You know, people with blood pressure and heart problems will come up and say "oh, I've got angina" or "I've got a touch of blood pressure", but nobody came up and said "I've got diabetes". And, I suppose... I mean, although I said that I don't think there was any stigma attached to it, but I'm sure people, perhaps, who were suffering felt that there was a stigma attached to it. And, although they will confess it to the doctors, but they would certainly not talk it socially.

Why did you decide to come to England?

Well, initially the idea was to come here and get my higher education, and then go back. And that was... you know, the whole idea was to try and come here for about four to five years, get some experience, get the higher education, and go back to India. It never happened; I'm still here, but that's a different story.

(3) You'd already done two years of house jobs when you arrived in Britain in 1970. How were your qualifications regarded when you came to this country?

Well, those days were easier, because initially I could apply to become a full member of... not a full member, but get full registration General Medical Council, at that stage, even before setting foot in this country. So, I could apply from India, and get my full medical registration on the basis of the house jobs and the degree that I had. So, there wasn't a big problem in that sense.

And had you got a job to come to when you arrived?

No, I didn't. I came with what used to be called a job voucher scheme. So, I applied for it in India, got the necessary voucher, and I came with my wife and my child, who was about a year and a half old, at that time. But then, I had family in England, which was, of course, a big support. My wife's brother was already working as a paediatric registrar in East England, and we actually came to him initially. And then I started looking for a job, but I didn't have the job before coming here.

Tell me about the first job, then.

Well, started all with locums, because initially, obviously, I was very new; I didn't know the system. I recall not having any initiation to the hospital or to the job. You just started with a bleep in your hand, and the bleep started to work straight away, and that was that. So, yes, initially, it was a few locums around in East England; mainly Colchester, Ipswich, places like that. And then, from there, on to Nottingham, when I got my first regular job. So, difficult days, but a lot of experience in those days.

Any experience of diabetes on the locum jobs?

No, I had no experience of diabetes. In fact, I was doing a locum mostly in paediatric specialties. So, my first encounter with proper diabetes, in this country, came when I moved to Nottingham in 1970, '71.

What was your job?

Well, I was a SHO in general medicine, and this was a sort of peripheral hospital, which was really not for acute admission; this was more planned admission. But it had a lot of longer-stay beds. One of the consultant that I worked with was a diabetologist in the local hospital, so, more or less, I started with diabetes straight away, as soon as I came in here. And I was responsible to look after a female and a male ward, where, in those days, my consultant - and other physicians - used to bring in patients, again for stabilisation on insulin, or those who had complications like neuropathy or foot ulcers, and things like that. And

they needed, sort of, care within the hospital environment for weeks and weeks and weeks. And I was responsible for them. In addition, I was also doing one clinic a week in General Hospital - so called General Hospital, Nottingham, which I think

(4) is now University Hospital, Nottingham. So, I got a lot of experience in that one year of working there.

Can you remember what the clinics were like?

Horrible, in terms of number, because I can't remember ever finishing before half past six, quarter to seven in the evenings - this is an afternoon clinic we're talking about. We had new patients and we had follow-up patients. We normally clerked all the new patients, and then the consultant came in and decided what to do with them. But then the follow-ups were there, and it was really a lot of hard work. We didn't have any blood sugar measurement facility, at that time - not on the day of the clinic - so it was all done on urine analysis and patients' own perception of how they felt. Of course, the patients were doing their own urine test at home, and that was a kind of guide as to whether we should increase the treatment or leave it, whatever. The results of blood sugars usually came a week after the patient had gone home, and if we found that the sugars were too high, or there was a reason for concern, we will contact the patient directly and ask them to come back again. But that's how it worked, really, in those days.

Would the patient have seen anybody else: a nurse or a dietitian or a podiatrist?

Yes, we had a facility of dietitian. And, I think, in the very first job - yes - there was a podiatrist, as well, for foot care, yeah. But that was only in one hospital. Subsequent move to other hospitals, where we didn't have any of that facility. So yes, that particular hospital was probably advanced for its time, in that sense.

Is this the General Hospital?

The General Hospital, Nottingham, which is now, I think, University Hospital.

And what role did you play in determining the patient's diet?

Not... you know, apart from general advice for the patient about their carbohydrate intake and low fat intake, et cetera, et cetera. We were not the expert, really, to give them detailed dietary advice; this is why they went to see the dietitian. But, I remember... I mean, I've been involved in diabetes for so many years, and various kind of diets have come, and various consultants had their own ways of looking at diet. You know, they often, almost arbitrarily, decided this person should have a thousand calorie, this person should have fourteen hundred calorie, this person should have two thousand calories per day. There were others who were going by portions, and they would say one

(5) portion of ten gram carbohydrate, and he should have, you know, six portions or eight portions, or whatever. And then this was up to the

dietitian, then, to try and work out around that, and produce a diet sheet which made sense to the patient.

So, we're talking about 1970 to '71, that there were really kind of two approaches going on: the calories and the portions?

Yes, the calories and the portions. But, I mean, it didn't just stop there, because I certainly remember working in Heartlands, previously called East Birmingham Hospital, where the consultants were still working on portions - and I'm talking of between 1972 to 1975 - and the dietitians were trying to produce a chart accordingly. This was also a time when this consultant decided that we haven't got enough Asian diets or diet sheets, and asked me to produce a diet sheet in Asian, in the language that people could read. And we worked on that, and we produced something at that particular time.

Can you remember when that was?

Well, this will be around 1973, '74, when, you know, we were drawing up the size of a spoon: how much flour one should have for chapattis, and how much rice, et cetera, et cetera. Because, prior to that, there wasn't any particular Asian diet; were all built around two potatoes, and, you know, other things. And a lot of Asian patients just didn't understand what to eat and what not to eat.

We'll come on to Heartlands in a moment. But still back in Nottingham, working out these calories, and you said that the numbers were decided rather arbitrarily.

Well, not arbitrarily. I mean, from what... you know, the basic principle was, was the person... somebody an office worker, a blue-collared worker or a manual labourer, and, you know, the basis of calorie ration was dependent on how much physical work they were involved. And if somebody was sedentary, and especially if they were overweight, I seem to remember they were given thousand calories, even eight hundred calories a day. I think it was a totally unrealistic target, even in those days, and I don't think many people actually stuck it out. But that is what was prescribed for them, you know, eight hundred, thousand calories - just go on a thousand calorie a day, would have been wonderful. And some patients, I suppose, did and did try, and some lost some weight as well, but I think it was not a very realistic way of doing things, but that was the way.

You're talking mainly about Type 2 here?

Yeah, I'm talking mainly of Type 2, yes. The Type 1, of course, the dietitian's input was a lot more, because, obviously, with insulin, they have to have some food around that time, and the blood sugars were going down. And then to avoid any hypo-

(6) glycaemia, et cetera, et cetera, their portions were also spread out throughout the day. So yes, what I have said so far is mainly concerning Type 2, yeah.

And then, what are your memories of the wards, and the people who came onto the wards, in Nottingham?

Well, we had some very kind sisters and very hardworking nurses. And, I must say, the dedication that I saw in those days, I do not see it now, but that's because society has changed, and we have all changed, and... But the nurses and the support sisters were very, very good. I mean, if you wanted four urine examinations a day, it will be done, it will be charted out, it will be there, they'll be weighed weekly; you know, looked after in many respect. And whatever the clinicians asked, really was provided by the nursing staff. So yes, a lot of cooperation with nursing staff and the doctors, and a lot of trust and respect for each other.

For the historical record, then, how did that commitment show itself, compared with nowadays?

Well, you know, times have changed. Perhaps we don't need that much dedication. We don't need to examine the urine four times a day, but, you know, it has been sort of superseded by blood tests, et cetera, et cetera. In those days, patients were kept in hospital for long period of time, and now that will be unthinkable, unless in very, very exceptional circumstances. So, the whole scenario has changed. And, you know, I'm not saying the nurses are not dedicated - I'm sure they are equally dedicated - but the job has changed, and the improvement in monitoring health has changed as well, so...

What are your memories of insulin from Nottingham, 1970 to '71.

Well, from what I remember, we had supply of soluble insulin, which used to be called, I think, NPH, and then we had the long-acting insulin - I think we had Isophane, and we had the PZI, protamine zinc insulin. The other thing was that it was available in three units: forty, eighties and hundred units, which is now hundred as a standard. It was available both as pork and bovine insulin; we didn't have any human insulin in those days. So, yes, there was plenty of supply of insulin, and the choice from which clinicians could try and prescribe for individual patients.

Any memories of particular patients?

From later, yes. I mean, I would go back to Heartland days, and I seem to remember one young pregnant lady who had several miscarriages. She was a diabetic, and she was unable to conceive, and she was having first trimester, or even later miscarriages, and had several of them. And when she became pregnant this time, my consultant brought her in. And she was literally chained to the bed pole, kept in hospital for the entire length of her pregnancy. And to our greatest joy and relief, she had a live birth, and she went home with a baby. And I cannot imagine, now, anybody kept in hospital for six, seven months, you know, away from their family and home. But that was wonderful in that sense.

(7) Tell me about your next job, after Nottingham.

Well, I worked in Highbury Hospital, in Bulwell area of Nottingham - I don't think that hospital exists any more - and then came to another hospital in Birmingham called St Chad's Hospital, on Hagley Road. I think it has got the

Area Health Authority Office now. Now, this job, again, was a medical job, and I was working as a SHO for medical consultants. Here, it was more acute intake, rather than the chronic patients that I was seeing at the other place. One of my consultant was an endocrinologist, so he did have one or two diabetic patients as well, but this was not a particular hospital for diabetes only. And, as I said, it was mostly dealing with acute medical emergencies, most of the time.

Should we move on to your next job, then?

And having worked there at St Chad's for about a year, I got a job as a registrar in Heartland Hospital, also called East Birmingham Hospital, in chest medicine. Now, by coincidence, one of my consultant, who was chest physician, was also diabetologist for Heartland Hospital. So, I got involved in his diabetic clinic, and also in admitting patients in his unit as registrar, and I was responsible for looking after them both in clinic and in the ward.

You've already given me two memories from Heartlands. One was of that pregnant woman, and also you said that some people were still talking about portions when you got there. What other memories do you have of those years as a registrar, 1972 to 1975?

Well, some humorous memories. I mean, I seem to remember going to the outpatient, and... Now, East Birmingham Heartland, where it is situated, has got a large ethnic population around it, and we were seeing, by that time, increasing number of Asian people coming to the outpatients. I seem to remember one particular gentleman, who looked very grim, very sad. He came for a follow-up appointment. And I asked... I saw him, and I said, well, you know, "how are you?", and he said "well, as well as you expect". And he still looked very sad. And I said "well, are you okay? Are you well?". And this man - he was an Asian; he was, I think, from Pakistan - said to me that "illness comes from Almighty, and doctors are there to

(8) treat. Now, I've got an illness and what you have done is stop my food. How long am I going to last now?". And he was dead serious about it. I couldn't stop, literally not... I smiled, but literally I was laughing inside. Because, what he meant was that when you are ill, when you are weak, you eat to keep your strength; you make yourself stronger. And this is a very cultural thing as well. Now, what you're doing is: I've got an illness from the Almighty, and you're telling me I can't eat. Well, at that rate, I'm not going to last very long, am I? And I really thought that was hilarious. But another incident, and it's totally opposite to this particular one, was when this guy came in, and, sort of - again in outpatients - I talked to him. And he looked happy, he wasn't complaining, but I said"well, how are you doing with your diet?". And he said"well, I can't eat that much". I said "what do you mean?", because I thought, you know, the diabetic diets were really mean, in terms of quantity, so "what do you mean?" He said, "well look, doctor, you've given me a diet sheet. Now, I have to eat my own food, and then I have to eat the diet sheet that you have given

me, and I can't eat that much"! And again, I thought that was wonderful - wonderful, how people take messages from doctors to their home! But I thought I'll share these two very funny moments in my time.

Was it because the diet sheet was just English foods, so he had to eat his own Asian food first, and then the English food on the diet sheet?

You may well be right. I didn't think we had started on Asian diet, at that time, particularly, but... So, he may well have thought that this was part of the treatment, and that's his normal diet. And he thought, well, that's a bit too much for him to consume.

For those who don't know Birmingham, can you talk a bit about the area around Heartlands, and the kinds of people you were seeing?

Yes, Heartland is basically on the east side of Birmingham, and it's surrounded by several districts, which are now predominantly Asian areas. Very high number of Pakistanis and Bangladeshis live in that area. So, the hospital draws a lot of patients from that particular community. And, with the increasing incidence of diabetes, obviously, the numbers have grown and grown and grown.

You mentioned, earlier, that you were involved in devising an Asian diet sheet. Can you remember when that was?

I think it would be around 1973; yes, '73, '74, perhaps. And the idea came in our head that patients, increasingly, coming to outpatients were Asians now, whose diet is totally different to the indigenous diet. And it was not good enough talking to them in what size potatoes they should have, because we only used to go on the size of the potato, what sort of size of potato you should have, and tomatoes, and things like that. Because all the people... you know, Asian diet does include potatoes and all kind of other vegetables, but it's cooked in a different way, and it's eaten in a different way. And the basic ingredient - the chapattis and the rice - were not mentioned in the English diet sheet. So yes, we decided that we must work on, and we sat down with the dietitian and tried to work out the diet sheet, which eventually I wrote down in Asian languages and photocopied it, and gave it to the patients.

Have you any idea if that was happening all over Birmingham, or all over the country, at the time?

I couldn't be certain, really, but I don't think it was happening in the biggest diabetic clinic in Birmingham, which was based at General Hospital, only couple of miles from where we were. I didn't see any patients coming from there who had a diet sheet in Asian done for them. So, certainly not in Birmingham, in my knowledge.

(9) What were the outpatients' clinics like when you were a registrar, from 1972 to '75?

They were quite busy, and they were getting bigger, literally by the month. But we still had only one consultant, one of myself as registrar, and perhaps one GP

clinical assistant, at that time. So, we were still managing all the referrals, new referrals and the follow-up, between three of us, or, at most, four of us, at any one time. The bloods were still not available in 1974, '75, so we were still relying on urine test, and the blood results were coming some days later for us to read and, sort of, get in touch with the patient if necessary. But they were quite busy clinics.

And were there any ancillary services?

Yes, we had the help of a dietitian. I think chiropody was coming to... certainly, towards the end of 1974, '75, we were getting help from chiropody. But that was about all, really, in terms of ancillary service.

Was there any nurse who was always attached to outpatients, and would have built up a specialist knowledge, or not?

The nurse I remember very well was always there, and therefore she had a very good way of working or running the diabetic clinic. But then she was not, as such, a specialist diabetic nurse. She was, really, working other days for other clinicians in the same building. But, just by the virtue of running diabetic clinic for so many years, I think, yes, she has had that insight into how to handle things.

And can you talk a bit about what you were seeing, in terms of complications, comparing the early seventies to now?

Well, certainly we were seeing foot ulcers, we were seeing people coming with kidney problem, and we were seeing people with retinopathy. And retinopathy screening had become quite common, in that period. It was still in Nottingham, when I was there, but this was getting much more fashionable. And everybody was trying to play with the ophthalmoscope, in those days, without dilating the eyes, I must say. But we were still trying to do our best, under the circumstances. So, yes, we were seeing complications. We were not particularly connecting ischaemic heart disease with diabetes, at that particular time. We were certainly seeing people coming in with other problems.

Were there many amputations?

Some. Thankfully, these were mainly either, you know, one small toe, a little toe or something like that, so not big amputations. I think one or two, I remember, were pretty bad, with vascular disease, and ended up having a below-knee amputation. But I saw some of them in later years in general practice, and not necessarily in the diabetic clinic while I was still working there.

(10) Was there any education for the patients?

Apart from the discussion that they had with the doctor, when they were in the room, I don't think there were any special educational sessions, at that particular time. And I would say, in that sense, no. The most patients got - and these were enlightened ones - were given addresses of the British Diabetic Association, so they could get in touch with them and get some leaflets, but I don't know

how many of them actually got in touch with them. But, no, I would say there wasn't much education at that time.

And what are your memories of the wards in the early seventies?

Well, the ward that I worked in wasn't designed as a diabetes ward. It was a general medical ward with lot of chest patients; not tuberculosis, because we still used to isolate tuberculosis patients, in those days, in a different ward. But, you know, they were a mix of everything else, and the diabetics. We were bringing diabetics mainly, again, for insulin stabilisation; that seemed to be the commonest thing. We were admitting, once in a while, somebody in diabetic ketoacidosis, and then there were some patients who were coming in because they had foot ulcers and peripheral vascular disease. Probably they needed to come in to have their treatment, dressings, whatever, and be seen by other disciplines, as well, at the same time.

And any memories of individual patients from the early seventies?

Well, I seem to remember one or two, and certainly one young English woman stands in my mind. When we were talking about diet - and she was on insulin at that age - she told me, point-blank, that she loves chocolates, chocolates are part of her life, she is not prepared to give it up - come what may. And there was not a lot I could tell her. I mean, we did warn her, but then that was her answer, in answer to my warning. And it stands out, because she was so determined to carry on eating whatever she wanted to eat. I felt a bit of a pity, in my own mind, but there was not a lot I could do.

What are your memories of pregnant women with diabetes in the early seventies?

It was taken very seriously by the clinicians, and it was explained to patients, in no uncertain terms, that we needed a lot of cooperation from them if they were going to have a live baby. Some of them already had experience of miscarriages. And because they were young, and they wanted a family, we certainly got a lot more cooperation from the patient, in terms of diet and other discipline. I think in the beginning of my registrar year, I cannot remember having active cooperation with the obstetricians. But towards the end - and I'm talking of '74, '75 - yes, we started to have clinics in common with the obstetricians. Before that, the diabetologists would look after them for so many years, but we'd inform the obstetrician that I've got a pregnant diabetic lady, and therefore they will plan a Caesarean at thirty six weeks, or thirty five weeks; something of that sort. But joint clinics came fairly late, in the mid seventies, from what I can remember... from my memory.

And can you remember how those worked?

Well, it was certainly a lot more better than, sort of, managing a pregnant diabetic all by yourself, as a diabetologist, because the other side, you know, obviously, we were totally ignorant about. And it made it very much comfortable for patients, and for the clinicians, to have two sitting in the same clinic: one

advising about the insulin, and the other advising about subsequent course of pregnancy. So, it was certainly a big step forward, I would have thought.

(11) Tell me what you did after you ceased to be registrar at Heartlands.

I straight away went into general practice. This was before the days of vocational training became mandatory. I was offered a partnership, of a sort, in Birmingham, and I decided to take that up. So, I moved in general practice in 1975. I kept my ties with the diabetic clinic, because my old consultant obviously knew me very well, and he offered me a position as a clinical assistant, for one session. And I wanted to continue working in diabetes just the same. So, yes, my contact remained with the diabetic clinic, in that sense, which was very useful in general practice, I must say.

What was the attraction of being a GP in 1975?

Well, it was not a very attractive job, because it was all sorts of hours, the money wasn't very good. But I think the one thing that was important from... personally for me is, with a growing family, I wanted one place to stay and, sort of, settle down and get a house, et cetera, et cetera, because, until such time, while I was in hospital, we were just moving from one hospital to another. It was the stability of the job, really, more than anything else.

You say it was very useful for you, as a GP, to maintain your link with the hospital. How did that work?

Well, because diabetes was one subject which, I think, not every general practitioner felt comfortable. Well, lot of them didn't feel comfortable in those days, either because they felt they hadn't been trained enough, or they hadn't enough experience of dealing with diabetics. So, any diabetics that they saw in general practice, virtually all of them were referred to hospital and were followed up in hospital. But, despite follow-ups, because some of the follow-up appointments could be six months to one year, patients came to the general practitioner in between. And if you had some working knowledge of diabetes, it was good to be able to talk in an authoritative way, and be able to give advice, et cetera, et cetera. And I found that very useful, from that point of view.

What kind of area was your surgery in?

It was inner-city Birmingham, again with the high Asian population around. And the surgery, although had a small number of Afro-Caribbeans, and some Irish, and some other ethnic white Caucasians, it was 60% Asian practice.

And what kind

(12) of incidence of diabetes?

Well, we were, you know, beginning to see more and more, and obviously... But I must say, the general practitioners' involvement in diabetes was minimal, really. Apart from referring them to hospital, they simply washed their hands of these people. And I don't think patients expected anything, either, from general

practitioner. If they did ask, you know, they were just told "well, you go to hospital, you ask the questions there". So, it was not impacting in that sense. You know, we are much more involved in diabetes now with the... in the new contract, the last three years, but before that, I don't think there was such an intense involvement.

And can you talk about being a clinical assistant for... What was a clinical assistant in the late 1970s?

Yeah, I mean, basically my job title changed from being a registrar to a clinical assistant. My work remained much the same, except that I was not then involved in any ward work, because I was only doing outpatient once a week, and that was the only difference. But, in a way, still seeing new patients, old patients, dealing with whatever came through the door on that particular day. The difference, really, in terms of being a registrar was that it involved a lot of in-patient work, and the clinical assistant was really confined to the outpatient.

You say that numbers were growing - both in the hospital and in your surgery - and you were in a mainly an Asian area. Were you thinking that the incidence among Asians was particularly high, or not, at that stage?

I must say, I sort of overlooked that; you know, I should have perhaps have spotted it earlier. But, you know, it didn't occur to me until fairly late that the incidence was very, very high, and a lot of people who were coming were Asians. I mean, the impression, initially, was that perhaps we were screening more people, and doing more... you know, the blood test had come about in the market, at that time, and people were having their random bloods checked. And that was bringing in the incidence. But, I think, also the fact that the Asian population who was already here was beginning to get older, and now people were in that age group where Type 2 diabetes commonly shows up. So, yes; initially I didn't, but yes, I think eventually it occurred to me that the numbers have increased, and they are increasing very, very fast.

Can you remember what years "eventually" refers to?

Well, I would say from 1980 onwards, it seemed pretty obvious. I mean, the diabetic clinics started to become

(13) very, very large. From doing one clinic a week with one consultant, and others had two or three members of other staff, Heartland expanded into having a full department where there were... I think there are seven or eight clinics, now, a week. And there are about six or seven consultants, with a professor at the helms of things. And all the clinics are full. Even now, because, I mean, I was working there until April last year, and the clinics are still very, very full. So, from one clinic to six or seven clinics, from one consultant to six or seven consultants, and forgetting, you know, not talking about the senior registrars and the clinical assistants and the hospital practitioners. You know, the number of staff increase actually shows the number of people now attending this hospital.

And what were your reflections on the incidence of diabetes among Asian people?

It was an explosion. It just felt like an explosion. Every... And it still feels like an explosion. I almost sense, being a general practitioner, that if I were to offer global detection test for diabetes to every single patient of mine, I honestly worry what sort of percentage will actually show up as diabetes. We're offering random testing, but we're not offering it to everybody. But I just wonder, if I did offer, how many of them will probably not be diabetic per se, but will have impaired glucose tolerance test. And I think the numbers will be very, very high. I think there's a lot of hidden diabetes in the Asian community, even today.

Why?

Well, I think it's a question of resources, you know. I mean, it's really an epidemiological work. And if the State wishes to take such big epidemiological work, then they will have to put in a lot of resources. They are already random testing and screening in Mosques and Gurdwaras and Temples, and people are coming with letters from these nurses saying, you know, impaired blood-glucose tolerance test, or high random sugar, et cetera, et cetera. But, I think if we were to offer it to everybody, a mass screening test, especially within the Asian community, I really feel that the explosion would be like... you know, it's like a time bomb ticking. The numbers will almost double overnight.

I meant, why the high incidence among Asian people particularly?

Well, there are all kinds of theories about diabetes and the Asians. I wonder, as well, just as you do, because as a

(14) young person, I don't seem to remember seeing that many diabetics within the community. My family was fortunate enough not to have diabetes as part of the family history. But I couldn't remember seeing, you know, remember many people on insulin, and things like that, in the sixties, when I was still in India. I think lifestyle has got to do something with it, definitely, and the diet. Now, I don't think there is anything wrong with the Asian diet, as long as the portions are normal. I think what has happened is that people are eating bigger portions, because they can afford more food, and they are not interested in taking exercise. So, the incidence of obesity is increasing, and with obesity is coming Type 2 diabetes. And this is becoming very common. I think it's a lot of... lack of education, and I really feel that we have to, rather than mass screening, we could do mass education on diabetes, diabetes, diabetes. Because I still, in general practice, see children who are, you know - not unlike the child who was on television the other day - fourteen stones. But not to that extent, but, you know, twice their size. This is not healthy. A lot of people who have come from India and Pakistan, they have come from rural background, where they did a lot of manual work, and they needed a lot of strength to plough the field and to carry the water, et cetera. So, unless you had the strength, you were not able to do it. So, if your child is twice the weight of an average child, you know, he's going to be a good labour... you know,

he's got a good potential for a good, hard working labourer. And that culture is still here, and that's why the over-feeding and, you know, sort of looking at these kids as healthy kids is still there.

And when you say "we" need to concentrate on education, who's the "we"?

Well, as a community, I think. You know, our National Health Service is spending a fortune on management of diabetes, and I think it not just is a part of the, you know, the job of the State, but I think from the schools, from the community centres, from councils. This message has got to come out loud and clear, time and time again, because I still feel that there are a lot of people have just not taken this message. The other thing I... I mean, this is a digression from diabetes, about, for example, breast-feeding. I see this as... a very insignificant proportion of Asian mothers breast-feeding their kids, and I don't understand why. I talk to them, I ask them, and they have no answer. They simply sort of shrug their shoulder and walk away, kind of thing. So, you know, the education side is still there. I think bottle feeding, you could make your child fatter by bottle feeding, and that's probably one of the reasons why they're not breast-feeding.

(15) Can you summarise what you see as the main changes at Heartlands, from when you started in 1972, up until you finished in 2006?

Yeah, I mean, I would say from 1980 onwards, the actual number of people coming to the clinics were increasing. Also, I'm not sure whether that impacted on it, but General Hospital ceased to function in the city. They had the largest diabetic population there. Some of them got transferred to Selly Oak Hospital, and others came to Heartlands, so our numbers increased. But, because of the increasing incidence, the clinics, per week, had to be increased from one, now to I think about eight a week. That also meant there were more physicians with a special interest in diabetes, both as consultants and in the training grade. And also GPs were working either as clinical assistant or hospital practitioner. But what I did notice was that we were getting more and more specialist clinics. I have mentioned the obstetrics and diabetic joint clinic. But we are getting things like diabetes and renal clinic, for example. Diabetes with - not necessarily a clinic - but in very close association with peripheral vascular... the vascular surgeons, to keep an eye on some of these things. The chiropody input was getting more and more intense, and more and more important and organised. So, you know, basically we were expanding into more specialised clinics, as well as the normal general clinics for diabetes.

What about eyes?

Yes, of course. I forgot to mention, there's a special clinic with the eye doctors. Also, I mustn't forget to mention that we have got some very decent facility at Heartland for retinal photography. Previously, it was ophthalmoscope, and in the later stages of my practice there, we started to get dilated pupils, so the nurses were putting in drops before the patients were examined. But now, certainly, with the retinal photographs, it is getting much more quantified changes that

you could follow up by serial photographs, et cetera, et cetera, so the service has improved enormously.

Can you remember how the role of nurses changed over that period?

Well, you know, the

(16) nurses have come on their own, haven't they? They have become diabetic specialist nurses. I don't think anybody's now admitted to hospital for insulin stabilisation, or if they are pregnant, et cetera - as I have mentioned in my earlier statement - because we have got such wonderful help from nurses now. And these ladies will be in touch with the patient by telephone, by home visits, and they will initiate treatment. Often they will adjust the insulin dosage, et cetera, and keep patients within the community, which is a much more satisfactory way of doing things now.

Can you remember when that specialist nursing started at Heartlands?

I'm trying to think, but I think it will be around 1985, '86, that the specialist nurses started to be trained, and then we started getting some input from them. But initially, all used to be just in the diabetic clinic. Now we're getting them within the community itself.

Can you remember how you felt about it, initially?

It didn't bother me very much, because we were working as a team. And, as I had input in hospital, I knew most of them, and most of them were very good friends, and basically we got on very well. I think, initially, some GPs were... possibly resented them, because these girls knew more about diabetes management than most of the average GPs, and they felt a little bit threatened about it. But, I think, in due course, everybody has taken to them. I mean, you know, we've got specialist nurses for a lot of things, and most GPs are very grateful for the help that they can get from these girls.

And you mentioned that GPs worked sometimes as either a clinical assistant or a hospital practitioner. Which, or when, were you each of those? When did you...

Became one? Yeah, the hospital practitioner grade for myself, I think, came in 1986, '87. I can't exactly remember. But, you know, this is just a change. I mean, there isn't a great deal of change in the nature of work that I did. Perhaps I got a bit more money, and, technically, a hospital practitioner becomes an independent practitioner, independent of the consultant. Whereas, as a clinical assistant, you are still supposed to be under - not supervision - but, you know, under consultant most of the time. So, not a lot of change in working pattern, really. However, I already had very good relationship with the... my professor at hospital, and that really didn't made any change. In fact, it was him who pushed me on to become a hospital practitioner, because he felt that, with my postgraduate degree of MRCP from UK, he felt I - and with the experience that

I had - he felt that it was not very just that I should just continue as a clinical assistant.

(17) You've been in general practice since 1975, and you're still in general practice part-time. What have been the key changes during that period?

Well, looking back between '75 and 1985, I think the work of general practitioner remained quite unchanged, to a large extent. It was still older style practice: seeing patients, prescribing, and letting them go home. I think the period after 1985 was certainly different. I think more practice nurses started to come in, because - except for some teaching practices, and some sort of very large practices - not many practices had practice nurses. And how could you do anything, really, without having a nurse in your practice? So, after mid-'85 - yes, I think even my practice employed somebody as a full-time practice nurse. 1990 was the fund-holding year by the Tories, and that certainly brought in a lot of change, very, very quickly. It certainly empowered general practitioners in a way they never had before, by holding a fund and by talking to Trust as to what services they wanted to have. And there was quite a bit of carrot for them: if they saved money, et cetera, et cetera, they could keep some of it for their practice development. So, the big changes were, you know, between '85 and '90, and from '90 onwards, I would say.

Were you in favour of GP fund-holding?

Well, I didn't understand it, initially, because, you know, basically I'm a doctor by training. And when you start getting funds - and how many millions you can have, and how do you spend it - it was all very complex. We had to employ some professional people, from our management allowance, to have an input. But, yes, I think after the first, you know, first very difficult twelve months, things started to sink in, about markets, and how to buy, and how to use your money, et cetera et cetera. But then, sadly, as we were getting proficient and managing fund-holding, it was sort of all abolished in one go by the incoming government, and we have now a different system to play with. So, initially not in favour, but I could see a lot of benefit coming from fund-holding. I think it was a good thing, and should have probably been left in place.

Did it affect people with diabetes?

Well, it didn't affect them directly, as such, but it did affect them, because, you know,

(18) practice, for the first time, had money to employ nurses, for example, or have dietary input. In fact, in the fund-holding days, we used to get a dietitian to come to our practice once a week, because we could afford that money for her. And that way, of course, it was all going towards the patient; it wasn't going to benefit us directly. But, it was making our work easier, by saying: "you go and see the dietitian today", or "you see my practice nurse today, you need your serial bloods done", et cetera, et cetera. So, yeah, it certainly helped us quite a lot, and the patient.

You say that GPs used to automatically to refer to hospital. Can you remember when you began to treat people with diabetes more in your general practice?

Well, personally speaking, we were doing exactly the same as everybody else was doing. And I would say, probably, not before the start of the new contract, that in all honesty, I would say, that one has started looking at referrals very, very carefully, because it impacts on the Quality Outcome Framework, the QOF points. Plus, also, every referral has a cost implication. And also the fact that the hospital follow-ups are really, in all honesty, not very good, because the patients are not seen in less than six months' time, and their blood sugars could be anything but normal. So, I would say, the last three or four years has seen a major shift from hospital-based clinics to community-based clinic, and this is going to be more and more. But, I must say, I mean, I know of colleagues who have started... or start sending patients to diabetic clinic, possibly in the sort of end... towards the end part of 1990s and beginning of 2000. We didn't. But I felt, I suppose, I had a bit of a vested interest: I was working in the local community hospital. And patients... you know, I was... rather than seeing them here, I was seeing them there. So, you know, I didn't want to see the diabetic clinic contract in the hospital. Not because of any financial reasons, but I just felt, initially, that my... you know, I was a bit apprehensive. Did we have enough resources in general practice to look after all the diabetics? Did we have the knowledge-base - and I don't mean just necessarily myself, but my other colleagues - to handle diabetes? But, I think it was not so much the knowledge, it was the resources, you know. I could see when I went to a diabetic clinic, I had the dietitian on hand, I had the trained nurses - the so-called specialist nurses - on hand. If I prescribed insulin, all I had to do was to say "go and see so-and-so", and this nurse will take this person through all the pens and gadgets and everything else. We didn't have that, and we still don't have that much. But, I think what has happened is that, because of the incentives of Quality Outcome Framework or QOF, more and more GPs are dabbling their finger. And because they are dabbling their finger, they getting the experience and they getting the confidence of managing them in general practice. Plus, also the fact that, despite all the resources in hospital, one could say that really the patients do not necessarily get all that much benefit, because the follow-up time could be anything between six and twelve months. And a lot can go wrong, and a lot does go wrong, in that sort of time.

Can you remember when you started having a specialist diabetic clinic in your surgery?

In the last five years, we have run our own diabetic clinic. And this carries on, until... to this day. So yes, it's a good five years.

(19) Let's imagine a patient coming to you with the symptoms of diabetes now, in 2007. Can you describe what it would be like for them now, compared with how it was when you first started in general practice over thirty years ago?

Yes. Patients will be seen within the practice. And they will probably see the doctor, initially, but they will be referred back to the practice nurse for all the bloods, et cetera, et cetera. They will probably see a dietitian within the practice, or - either in the practice itself, if it's a big enough practice in a health centre - or they'll be referred to a local dietitian within the community clinics. It's not necessary that every patient will be sent to hospital automatically, because there are enough community-based clinics. And there are some community-based diabetic specialists as well. So, if a general practitioner wants some urgent advice, he can get on with this community diabetologist and get some advice, or refer this patient directly to the community diabetic centre, rather than to hospital. So, the emphasis is transferred from the hospital to the community-based clinics. The ones that will be left out with the hospitals will be the ones who have got a lot of complications, on different insulin regime, perhaps, those who are having multiple injections a day, pregnant ladies, juvenile diabetics, et cetera, et cetera. But I think the majority are now being taken care of, and the emphasis is getting patients discharged from hospital. So, those who are already in the hospital system, they are being asked... you know, we are making... requesting the hospitals to actually discharge them back to our care, so we can continue to see them in the community. So, there's a sea-change from that point of view. Whether it benefits the patient? Well, I think, certainly, it's very convenient for patients, because they know their practice, they know their doctor, and they can come umpteen numbers of time if they have problem, unlike hospital, where they have got very rigid six month or twelve months appointment system. And it's very difficult to get in as an extra, unless you really, you know, sort of make a fuss about getting into it for... and you must have a very good reason to get in there, as well.

Is there any tension between hospitals and general practice?

I have worked on both sides. And I think - I don't delve in politics that much - but, yes, there has to be a certain degree of tension, because

(20) the hospitals have got their own empires, and those empires are being threatened. I mean, I can well see if 60 or 70% of patients are going to be managed in the community, what justification will be there for, say, having seven or eight consultants in any Trust, and why there should be that number of clinics. So, instead of the clinics being increased, the numbers would come down. And I can see resources being sent into communities. Perhaps some of these consultants will start working in the community, rather than just working in the hospital. So, yes, there is some tension, and there's bound to be, because the working practices of people in my generation, and even those who are at least ten years younger than me, is being changed completely. I mean, one of the reasons I retired was that the changes have been far too many, and I decided to quit. But for people who are ten years younger, they can't quit, you know; they've got to work. So, there'll be some tension.

You say you retired because the changes were too many. Was it that you didn't

like the changes, or too much admin, or. . . ?

I think the changes are too many in reorganisation after reorganisation after reorganisation. Before you get used to one set of working life, you know, you've got somebody else coming in with some brilliant ideas. I mentioned GP fund-holding earlier. I didn't know it, I didn't like it, but once I got to know it, once I got to like it, and by the time I got used to it, it was changed and it became something else. And by the time I got used to second kind of reorganisation, then came Practice Based Commissioning, you know, so it's an ongoing saga. So, people in my age group, I suppose, you know, we're not sort of flexible that much, and it starts to get a bit too much for day-to-day working. From being a clinician, you start to become more and more and more an administrator and a financial manager, and all sorts of other things. You've got a lot more worry about other things, rather than just your practice and your patients, which is how my generation was not brought up, you know. We were brought up to look after patients, and that was your main concern.

Has your attitude to patients changed at all, during your working life?

I wouldn't say my attitude to patients has changed, but I think the attitude of patients towards us has changed. They have certainly been told that they have got more rights to expect, and rightly so. But the demands have increased, sometimes for political reasons. Unexpected level of. . . you know, they have been asked to sort of

(21) demand things, which really couldn't be met within the existing resources. But that's political spin. The lawyers have not helped by encouraging people to come and complain, and, you know, rather than having this trust of, the doctors did the best for you, and if something went wrong, you know, there may be a good explanation for it. People rush up to the lawyers and try and get money out of it. So, there are a lot of commercial aspect of things, which is coming to medicine, and which certainly people of my generation wouldn't like. But, my relationship from patient is, in the sense that I think the loyalties on both sides are getting less and less. We used to have, you know, this thing about general practitioner being, you know, "you're my patient and my practice and my list size". It's all going by the window, you know. We are not allowed to have a list size now, you know. If you are registered as a health centre, it's the health centre who is your provider, not a named GP. So, the loyalties are getting less and less, you know. Every practice has patients who move away from the practice area to maybe a few miles out of the area, and every practitioner used to have some of those patients. You know, we all had wise patients, you know, change your doctor, you know, nearer to you. But then, some, because you. . . we had known them for years, they had known them for years, and, you know, there was a relationship. That is getting less and less. General practitioners have got to be very straight-forward, you know, "sorry, you have moved out of the area. Out!", even though you may be a mile out. But if it came to you wanting something, the nurses may not

want to go in that area, because it's not in their catchment area, or the Trust is not responsible for that area. There are a lot of other logistics have come. So, I think, you know, the loyalty that we used to have to each other has certainly dwindled; it's not in the same extent. And certainly the patients expect much more.

(22) You've reflected on the change in relationship between patient and doctor. Have you any reflections on diabetes as a disease?

Well, I certainly feel that now that this is commonly diagnosed, it has less impact on patients' perception. But I certainly remember ten, fifteen years ago, that this diagnosis had a lot of social impact on the patient's life. Some of them took it in good grace, and were not particularly bothered about it. Others were completely devastated, and they thought life has come to an end. But the other thing is that I still find that a lot of people do not want to talk their - and I'm talking mainly of Asian population - they do not like to talk about their illness with other members of the community. They like to keep it a secret to themselves. So, yes, it can take some time before they accept the diagnosis, because, initially, they are in a denial phase. They'll eat whatever they want to, and they do whatever they want to do, except for some sensible ones, who would take advice seriously. Others will simply, sort of, either go completely, you know, be completely devastated, or the other group will try and ignore it at his own peril. So, it does have impact; it impacts people in different ways. As I said earlier, some of them will really feel that this is the end of the world for them. And it's only after a few months of treatment, when the symptoms improve, et cetera, et cetera, that they start feeling the benefit of it, and they feel that - and by telling them, showing them, examples of people who are within the community with the disease for the last twenty, thirty years - that they start getting some, you know, sense that what they are thinking is probably not the right way of thinking about it.