54. Joan Jones

(1) Tell me about your background.

Well, my father was a cooper - they're non-existent now. My mother never went out to work, and... but if she'd have had the opportunity, during the First World War, she always told me that she would have been a midwife, but training wasn't possible, wasn't easy then. So, I think she ended up in a bakery, forced to work. I went to school in a private school. I left when I was sixteen. My parents both worked really quite hard and had not a lot of money, but when I suggested, first, that I join the Red Cross, my mother was very keen, as a volunteer. The war, of course, hadn't started then. And then I thought, when the war came, that the best thing... I didn't want to go into the ATS, I couldn't get into the Wrens, and I was too short for the Land Army, so I thought the only other thing left to me was nursing. My mother was very keen, but my father wasn't. He didn't think nursing was quite the thing for young girls, really. But I think he was gently persuaded, by one means or another, by my mother, and I started my fever training. That was my first experience of illness: death and pain, really. And then, after I'd done my fever training, I went on, then, to do my general, and went on to do my part... I went down to London to do - because my friends were all going down to London to do their general training, and I thought that was great - so I went down to London and did my general training and my part one midwifery.

(2) Had you come across any cases of diabetes before you started your nursing training?

I do remember that there was one little boy of four, whose mother was a friend of my mother's. And it was a great tragedy, at the time, because diabetes, in those days, in a child, was quite a serious thing. And I remember them talking about that he had to be injected, which was a terrible thing for a child. And he wasn't a terribly good little boy, so they were very anxious about him; that, one, he would eat the things that he should eat. And I remember all this because my mother was talking to his mother. And I think, eventually, he settled down, but he wasn't really a terribly good diabetic, behaviour-wise, and he died when he was about seventeen. And that was the story, in those days, with diabetes.

Now, coming on to your training: What were the years of your fever training?

I started my fever training in 1942 (actually 1940). The war was on then, and...

What fevers were you dealing with?

We were dealing with everything, and, of course, in those days we had epidemics, which you don't hear about now. I nursed through epidemics of scarlet fever, diphtheria, meningitis, mumps, whooping cough; all the childhood ailments. And the hospital was quite near to an army camp, so we had quite a bit of meningitis in, and dysentery, and anything else that happened to be there at the time. But to nurse the individual cases that came in, we had a cubicle block where we did barrier nursing. On this block there were twelve rooms, and if there was an odd

infectious disease came in, from either the camp or anywhere else, it was put into one of these rooms and it was barrier nursed. The patient had all their own implements, the gowns were outside the room, the masks, the gloves, and if there was any question of cross-infection, I think the whole of the hospital staff were before the matron to find out why.

What was the name of the hospital?

It was called Clatterbridge Isolation Hospital and it was in Cheshire, near a very pretty place called Parkgate on the River Dee. And I spent two and a quarter years there, and finally qualified.

Did you come across any cases of diabetes?

Well, we did. Not very many, because by this time diabetes was being researched quite a bit, and patients were beginning to be taught how to manage their diabetes themselves. But if they weren't, then the district nurse usually went in to give insulin at the times that it was necessary. So, I didn't see a great deal, but I did see one occasionally.

People who came in with other diseases?

Well, they were usually very ill, because of the disease complicated with the diabetes, so we had two illnesses, really, to deal with, at that time.

Can you remember how it was dealt with?

Well, the disease, anyway, was dealt with the usual things that we did, but the diabetes, of course, had to have their insulin and bloods very carefully watched, because it used to fluctuate with the disease. And they were just managed with insulin, and diet, of course.

(3) Now, I remember the way we used to get our patients in to the fever hospital, because, of course, the infectious diseases were so virulent that we had to be entirely separate from any other hospital. So, we had our own ambulances, and we used to go out for patients. The doctors - the GPs - used to notify either the hospital or the local police station. And we used to go out for the original patient that was notified, and then we used to call in at all the police stations on the way to the original patient's address. And we used to find, very often, that if there was an epidemic, there were two or three names and addresses at the police stations, so we used to go out for one patient, very often, and come back with four. And this was the way we used to have to do it, to keep everybody isolated from everybody else.

And were these mainly adults or children?

Well, mainly children, but occasionally the adult had brought the infection into the house, so we'd get the adult and the children, the family in. And there was one particularly poor area that we used to go to where you could bet your bottom dollar that everybody had to be de-loused when they came in, from the

mother or the father and the children, right down to the baby. But that was part and parcel of it.

And if they had happened to have diabetes, you'd presumably have been informed.

Yes, the GP used to leave a message to say if there was a particular child with any other illness, including diabetes. He'd leave a message to say what insulin they were on and what diet they were on, and how they were.

Can you remember anything about the diet?

I can remember that there used to be a line diet - a diet called a line diet - and the diabetic had to have so many of these lines a day. That was to balance the food, and, of course, it was without sugar and all that sort of thing. But, it's funny; I was talking to somebody only the other day about this, and somebody that they knew was still on a line diet. And I was quite amazed, after all these years. But we used to manage the diets much as it's managed now: withdraw sugar and a lot of the fattening stuff, keep the diabetic's weight down, and made sure that they didn't eat anything that was any sugar in.

(4) Did whatever infectious illness they have alter their intake of insulin?

Oh yes; a great deal, sometimes. If they were hyperpyrexial - had raging temperatures - that used to have great bearing on the diabetes. They were having to have a lot more insulin, and they had to be monitored almost every hour to make sure that the diabetes was kept as stable as it could be. If not, then they'd go over into a coma.

Were you trained in the advance warning signs before somebody fell into a coma?

Yes. We were... as the diabetics came in, we were told how much insulin they were on. And in our junior days, of course, we weren't allowed to give insulin - it had to be given by a senior person, because, well, at that time, insulin was quite a new thing. We were taught how to watch for hypoglycaemic comas, and call for help as soon as we saw anything happening - sweating or clamminess - and then the sister or the doctor would come along and sort the insulin out again, take blood tests. A lot of blood tests were taken then. I don't say more than there are taken now, but different, because most of it had to be intravenous. Now, of course, it's so advanced, the patient takes the blood out of their own thumb, which is much better.

And what about monitoring urine?

Well, of course, everybody's urine had to be tested every day, but the diabetics' was tested four times a day. And any fluctuation, of course, had to be reported immediately, because then, again, insulin had to be looked into. So, it was a very complicated nursing case, really, to have a diabetic in.

Can you remember anything about the urine testing?

For the urine testing which was done every day, and some, for the diabetics, was done three or four times a day, I seem to remember we used... we certainly

used litmus paper to see whether it was alkaline or acid, and, I think - I'm not sure - I think we used a solution called Fehling's. But I can't remember much about that now - it's a long time ago.

(5) What did you do after your fever training?

Well, after my fever training, the war was on, and life to somebody young was a little bit exciting, even though it was a war. And I decided that a lot of the friends that I'd trained with had gone down to London to do their general training, and I thought that was quite a good idea, I'd go down too. I didn't realise just how wonderful it was going to be, because, of course, in the middle of the war, we were right in the centre of London, and I saw far more than I ever thought I would see. But I did my training.

What years?

That was from 1943 to '45, '46. Now, because I'd done my fever training - that was two years and three months - instead of having to do four years general training, they used to cut it down to two and a half years general training, because we'd got the extra qualification, which was quite good. General training was a very mixed bag. It was very good training, because, of course, we had war casualties as well. I saw, there, quite a lot of diabetics coming in as casualties, and also coming in with other problems, for ops and other medical problems to be dealt with. And, of course, their diabetes, again, had to be dealt with. Things were improving slightly then. When I say improving, I mean there was a lot of research going on into diabetes and insulin, and it was more manageable. Patients were getting less comatose, because now we were managing to get the insulin better controlled. And we didn't have, at that time, we didn't have an insulin called protamine zinc, which was a longer lasting insulin; we only had the soluble insulin. But when the protamine zinc came in, we were able to mix the two insulins, so that instead of giving the patient two or three injections a day, we need only give them two: one in the morning and one in the evening. And as long as their diet was watched very carefully, and the patient behaved - we always had to take this into consideration - they really did quite well, on the whole.

What do you mean "if the patient behaved"?

Well, not all patients are terribly good about their diets. Even

(6) now, I've got several friends who are diabetics, and if they can go off the rails a bit and make it all right for themselves, they do. And it was even more so in those days, because patients didn't... had to be taught just how serious diabetes was. Now, I think, the patients are told that, you know, you can live a perfectly healthy normal life and get on with things, as long as you do the things that you should with your diet. But in those days, of course, it was still a very serious thing that had to be coped with, as well as live as normal life as possible. They didn't always behave with their diets, and so, of course, we used to have several patients that we got,

in the end, to quite recognise as they came through the ward door, back again, because they hadn't been eating the right thing, or they hadn't been perhaps having their insulin at the right time.

Were they referred to as the 'badly behaved' patients?

Nobody ever said a patient was badly behaved! But we knew they were sometimes. And, of course, it was difficult for them, in those days, because diabetes being treated as successfully as it was, was in its infancy. So, patients still had the idea that if they were a diabetic, they'd die; and they didn't.

Can you remember that, that people thought they were going to die?

When I first started training, yes. Between the time I knew that little boy and I went... I started my training, patients... diabetics did die, because they only had to get a severe infection, which tipped over the diabetes, and it was out of control. They went into a coma and they died. I do think that from the time that I knew this little boy, who died when he was seventeen, things had improved with the diabetics, because when I was doing my general training in '43, '45, we were... diabetics were living and managing to live a reasonably normal life, if they behaved. The diabetics who were in the greatest danger of all were the diabetics who became pregnant.

Do you remember many of those?

Oh, yes. I didn't see quite so many when I was doing my general training, when I did my part one midwifery to follow, because we did part one midwifery for six months, so I didn't see a great deal of diabetics then. But I saw a lot when I was at Loveday Street, Birmingham Maternity Hospital, because one of our consultants had specifically a diabetic clinic, which he ran with the diabetic physician, the Professor of Diabetes, from the General Hospital, Birmingham.

(7) Before we move on to your midwifery experience, can you tell me what hospital you were in for your general training?

Yes, I was at St Mary, Islington, Hospital, which was a London County Council hospital. When we were in training, the first day we went onto the wards, we were given a large sheet of paper, which was our schedule. It was all marked off as to all the procedures that we would learn and have to do while we were doing our general training: things like treatment of bed sores, catheterisations, dressing of wounds, making patients comfortable in bed, doing the bedpans, doing the bedpan round, observation of the bedpans, which nobody ever does nowadays. And then, when we had done this particular job, at the end of the day we would take our schedule to the sister of the ward, and she would sign it. And then we would keep this schedule until we sat our exams. And this schedule went with us to the exam, and the examiners were able to check that we had done all these procedures that was expected of us during training. It was quite an effort, really, to remember to get all these things in, because it depended upon the ward that you were on as to how much experience you got. Some wards you got a lot of... if you were on a genito-urinary ward, you got a lot of experience with catheters

and care of catheters, and care of patients, and inserting of catheters - male and female - and observation of bladder problems, and... So, you wouldn't get, perhaps, so many injections to be given. You'd learn that on another ward. And so it went on. Each ward you went on, you gained more experience. So, you had to watch your schedule very carefully, because, at the end of the day, if there was something you hadn't done and you were examined on it, you didn't know anything about it.

At what stage in your training would you have injected someone with insulin?

Usually you didn't inject a patient with insulin until you were about a second or third year nurse, student nurse.

Let's move on now. What did you do after you completed your general training in Islington?

Well, I stayed on at St Mary's, because they were also a part one midwifery training school, and so it was easy for me just to switch over. And it was quite a good training school - it was recognised very well as one of the better training schools. So, I stayed there for a further six months and did my midwifery training. But, before we were accepted, you didn't, just because you'd got your state registration, slide over to the midwifery. You had to go before the matron and the medical officer of health and be interviewed to see if you were suitable, even though they'd trained you to do further training with them. Fortunately I was, so I did it!

(8) After I did my part one, not a lot of nurses went on to do part two, but I did. And I did it in a small hospital called The Limes in Stoke-on-Trent in 1946. Part two was six months, and there you were trained... you had three months in the hospital learning how to deliver a baby, which you already knew about, but without assistance. Nobody of seniority was there. You were really being taught to deliver babies on your own, ready to go out on the district. And the second part of the second part was three months on the district, on your own, with just the doctor or the senior midwife on call. And then, after that, I went as a staff midwife to the City General Hospital; that was in 1946. I didn't stay there very long - I didn't like it. And then I took a post as midwifery sister and night sister at a little hospital called Crosshouses, just outside Shrewsbury, and I was there from '46 to '49. Didn't see a lot of diabetics there, because Shrewsbury General Hospital used to take most of them, and they were kept there. Then I went on to Dulwich Hospital, and I was there from '49 to '55. And after that, I came to... I got a post as outpatient sister in Loveday Street, Birmingham Maternity Hospital, and I was there from 1955 to '63. And there I saw a lot of diabetic patients, because until then - it was dreadful - but diabetic patients used to come in, and we knew very well that they would invariably have a stillborn baby, because the result for the baby in a diabetic patient was nil. But Loveday Street, there were two consultants there who specialised in diabetes in pregnancy, and they were

very successful at getting live babies. And these patients were brought up to the hospital every week to be checked, and then, when the time came, it was usually... they brought them in a little bit prematurely, and they had a Caesarean section. They were not allowed to go into labour. And, I should think, eight cases out of ten, they had a living baby, which was great for everybody concerned.

Had that not been the case when you'd been at Dulwich previously?

No.

(9) Until then, I'd never seen a diabetic come away with a living baby. And they were always huge babies, very big babies; at least ten pounds. There was something about the diabetes and... I don't know. But they were quite successful at the maternity hospital at Loveday Street.

Can you remember the name of those two consultants?

Yes, I can. One was Professor Malins - he had clinics at the General Hospital, Birmingham, and the other one was Dr Samuel Davidson - he was the obstetrician. And between them they ran the specialised diabetic clinic. All the diabetics that came to Loveday Street pregnant, all went on to the Thursday morning clinic, when they were seen by both of these men. They were very, very good.

And you were at Loveday Street from 1955 to 1963. What are your own memories of treating mothers with diabetes during that period?

Well, of course, things were getting better. You didn't regard the mother with the same dread that you did before, because you knew that the chances were now, with these two men, and the care that they would receive anyway - not that they didn't have good care elsewhere, they did - but the end results here were so much better that it was easier to talk to diabetic patients and give them a lot of hope.

What did you do when you were in Dulwich, and you, as you say, dreaded meeting a diabetic mother? How did you talk to her?

Well, of course, most of the mothers knew, because they'd already been warned by the GP to try not to become pregnant, because, if they did, the end result would be a stillborn baby. And many of them were advised to adopt, if they could, and, of course, adoption was easier in those days. But we knew, and the patient knew, when they came in, and as soon as they were delivered, we had small rooms for them so they wouldn't be near the other mothers with their babies. And we sent them home as soon as possible, to be nursed at home. We thought that was the kindest way.

(10) And what did you do after you left Birmingham and the maternity hospital in Loveday Street?

Well, thereby hangs a tale, really, because we knew that the maternity hospital was going to be knocked down in redevelopment and various other things, and

that the midwifery would be going up to the Queen Elizabeth. And I felt that I would like to do something different, rather than... and it would have meant quite a little bit of travelling for me through the city, which I really didn't want to do. So, I decided that I would go onto the district and see how I got on there. When I applied to Warwickshire County Council, they would accept me, but all their district nurses had to be Queen's Nurses. Now, this didn't always happen in every county council, but Warwickshire County was most insistent that we were trained as Queen's Nurses. So, they suggested that we went to the Queen's Home in Birmingham - Summer Lane, I think it was, yes - and they seconded us. They paid our salary for three months, but I was on a senior sister's salary then, and we were only allowed to receive a first year staff nurse's salary for three months, which was quite a bit of a hardship when you had to keep a house going and a car, and all the rest of it. However, I went and I did my three months' training. And at the start of it, we were given a handbook called "Outline of District Nursing Techniques", and in it was all the procedures that we had to use on the district. And one, in particular, was how to teach a diabetic to give their own injections. And in each house - we used to check up every week on them - but they used to have a tray specially cleansed, clean towels, a holder - a glass holder or an enamel holder with the syringe in, sitting in spirit, having been boiled before - and their needles. And, if they were mixing insulin, you had to teach them how to mix the insulin, and then teach them how to give their own injection. Some patients did this very well; some patients ran a mile, so we had to go in and give it anyway, every day. But, all the detailed instructions are in this handbook, so you don't go wrong.

Your training was 1963. What's the date on that handbook?

The handbook training was 1954, so it hadn't changed a great deal from '54 to '63, except that patients were then beginning to be gradually taught to give their own insulin, which, of course, was a good thing, in a way, because it made them freer. Because when we, as district nurses, gave the insulins, they had to wait for us to come before they could have their breakfast, because insulin had to be given before breakfast. And, very often, I've got up at six o'clock in the morning when there's been a patient going out on a coach for a day, had to have their insulin and their breakfast early, and the coach had been calling for them at eight o'clock. We've had to get out and give them their insulin before they went, which we didn't mind doing. But it was so serious that they had their insulin before their breakfast and before they had any activity, otherwise they'd be in a coma on the coach.

(11) Any other memories from your Queen's Nursing training in 1963?

I always remember that our caseload was very heavy. We used to go out with... I happened to hear somebody... I read somewhere, recently - last week, I think - in the paper what a district nurse does now, and really I felt I could do it quite easily these days, compared to what I did then! We used to go out with a diary with at least twenty visits, and, of course, you had to spend time going between one visit and the next. Even if you were a car driver, it took time.

And, every week, we had to have an inspection round, so that one of the senior people - tutors - came round with us to every patient to see that we were doing the Queen's technique as it should be done, which was following the handbook and spreading plenty of newspapers on the floor. We always had to ask the patients if they had newspapers - they took a daily paper - because we'd need the newspaper to spread on the floor to save any drips, spills or anything else, because we were responsible if we ruined their carpets or spoilt their furniture. So, that was... we had a round done every week. And then we had a mini-exam towards the end of the training, and then we had the Queen's Nurses' exam, at the Council House, at the end of our three months' training.

You said that the training took place in Summer Lane, and I happen to know that that was an area surrounded by back to back housing. Were you visiting patients in back to back houses?

Oh, yes. We had quite a few patients in back to back houses, because Summer Lane and... oh, I've forgotten the name of the roads now, but there were... Icknield Street was one, yes, and they were nearly all back to back houses, and one toilet did about four houses. And it was very difficult, but we managed to do it. And people managed to look after themselves very well in there too, considering what they have now, compared to what they had then.

You talked about the very demanding caseload. How did that fit in with the rest of your life?

Well, of course, when I was doing my Queen's training, it was a daytime training. It wasn't the same as when I came out onto the district - we were on call. We started work at eight o'clock, as Queen's Nurses, and finished usually about between five and six, but we had to take turn on the rota to do the late night injections. Now, injections were given any time from ten till midnight, so you had an evening round to do, but that only happened perhaps once a week. Being married was a... it was a little bit difficult, because you weren't at home a lot of the time, but with an understanding husband, it worked out quite well.

When did you get married?

I got married in '55. Unfortunately my husband died in 1957, so I went... I really didn't stop nursing. I was nursing when I was first married, and then, when he died, I went really back to it, so I didn't leave it for any length of time.

(12) Moving on, then. After your Queen's Nurse training, you worked as a district sister from 1963 to 1982, so nearly twenty years. Can you talk about your memories from the early years as a district sister?

Well, I loved it. I mean, I'd loved my time in hospital, because it was all very exciting, and there was something going on, new, every day in hospital. But it was the same on the district, but in a quieter way. And we really did get to know patients very well indeed, because you took a patient on, and you never knew how long you were going to have them for. In some instances, one patient, I had, I thought I was going to have her when I retired, but I didn't - she died

a couple of years before I retired. But we did have long-stay patients. And we had a great deal of variation, because we covered a tremendous amount, really. I was the practice sister. We used to call them... We were practice sisters, then, in those days, because we... When I first came out, we used to do areas, so that we worked... any doctor that was working in our specific area used to send in cases to us. But then, a great change came - about 1974, I think it was - and we... they decided - 'they', the great 'they' - decided that it would be rather good if nurses were attached to the practice; the main practice of the area that they were in. And so we were called practice sisters. And we used to go wherever our own doctors went, then, which was a much nicer thing, because - I thought - because you had your patient and you knew your doctor, and you were in constant contact with your doctor, so it was a nice little closed shop, if you like.

But what was it like before you were attached to a practice? Where were you based?

Well, we worked from home. Messages were sent in by telephone to us. We had an office that was run by the area nursing officer and the deputy area nursing officer. They were two senior people who looked after the whole of the area. For us it was this side of Warwickshire - we're North Warwickshire aren't we? - North Warwickshire, but our main headquarters was in Warwick. So, all meetings were held in Warwick, of importance, but our work came from... we worked from home, and had to go into our local office for any problems, or anything that had to be sorted out. But the practice nurse covered,

(13) until 1974, she covered midwifery, general nursing - that was very sick patients who had to be completely nursed - diabetics, dressings, baths, observation visits, and a thing called loans visits, which they don't do now, and this is why it's costing the health service so much. If a patient came out of hospital with a loan - a walking stick or a wheelchair or a Zimmer walking aid or a monkey pole on the bed - we had to go every three months and check that that loan was, one, still being used; two, was in good condition, and if it wasn't then we used to have to give notice for it to be called in. So, the loans were very seldom lost. Now I know of people who've had loans for years, and nobody's ever bothered about them; anything from wheelchairs to walking sticks. So, that was part of our work. I hated it, because it was very boring, but still, it had to be done. Observation visits: they were visits that you just went to see - it was usually the over sixty-five, seventies... Anyone could stop you in the street, in those days, and say "oh, you know Mrs So and So", "Yes", "well, she isn't very well", so you would go and see her. You didn't have to ask permission, you didn't have to ask a doctor. You just went to see the old lady, because someone had told you about her. And if you felt that she was in need of a doctor, or he was in need of a doctor, then you reported it to the doctor and the doctor would go. So, we didn't lose patients by nobody knowing anything about them, as does happen, sometimes, these days.

They were observation visits - I always found them interesting. Weekly baths, fortnightly baths, we used to do. But joy of joys, about five years before I retired, they gave us a bath nurse, which lifted a lot of work from us, at that time. And she just did baths, and left us free to do a lot of other things that we slotted in or perhaps had to make time for, so that was a boon. Dressings, yes, anything from post-operation to chronic ulcers, we would do.

Did you see many diabetic ulcers?

We saw a lot of diabetic ulcers, and toes, of course. Gangrene was one of the diabetics' horrors. So, when we went into a diabetic, it wasn't just to give insulin. We had to check thoroughly that they were fit. But our diabetics, in my particular area, were

(14) extremely lucky, because, once a year, the hospital team used to come out to our practice and bring all their stuff, and we used to go in. And there was an evening when all our diabetics were seen by the professor, again, and his team of medicos and the nursing staff. And we used to go in to report our side of it, and what had gone on in the twelve months before. So, they were kept a very careful eye on; they were very well looked after. And general nursing, well, they were the patients who were usually terminal or incapacitated in some way - severe arthritics that couldn't manage to wash or dress themselves - and we used to go in and do it for them. And, of course, when I was doing midwifery, that all had to be fitted in. And when I think about it now, the instructions were, from headquarters, which was Warwick, that if we were up two nights doing a midwifery case, we had to ring in the third night and we would be relieved, so that we could get a night's sleep so that we would be safe on the road the next day to drive. Amazing, isn't it? And that was my district work, and, as I say, I loved it. A lot of paperwork to do. We had to fill in forms; we had the book to fill in - two books... three books, we had. We had our dangerous drug books that we used for... because we used pethidine and morphia, sometimes, for patients - pethidine for patients in labour, morphia for terminal cases - which had to be written up into the DDA book; Dangerous Drug Act book. And then we had a book where we wrote all our midwifery cases up in detail, and a book where we wrote our general cases up. And then we had a huge form, every month, to send off to headquarters, saying how many general nursing cases we'd done, how many midwifery, how many diabetics, how many dressings, in detail. And then we kept a diary, every day, with all our visits in, and our mileage, because I owned my car, so we got an allowance, so you had to put in how much mileage you'd done each day.

What kind of patients with diabetes were you seeing? What kinds of cases?

On the district, mostly elderly.

(15) Occasionally you'd get a child; not very often. But they were mostly elderly

patients, who, for some reason, could no longer give their insulin. They were either going blind, or perhaps they weren't strong enough, or their arthritis was so bad in their hands they couldn't manage it. So, we used to go in. I used to have about, perhaps, five, six, seven diabetics every day, and they had to be done first, because of breakfast. And then we would go on to do the general nursing cares, because they were ill and had to be attended to fairly early, and then we did the dressings. And it depended on what the dressings were as to when they were done. If they were clean dressings - post-operative dressings - they would be done early, and then baths would be done, and then dirty dressings would be done last. Observation visits and the hated loans visits would be done last of all.

These six or seven people with diabetes that you saw every morning were obviously terribly dependent on you, so what happened if you were ill, for example?

Oh, well, of course, if I was ill or I was off, then my relief used to go in. We were al... There was a group of three, so that there were always... the nurse on... I was on for the district, then I had my relief, who was usually the nurse on the next district, and then we had a second relief, so that... And this used to work very much in midwifery, because if I was out on a case, the next one would be on call. And if she'd gone out on a case, which sometimes did happen, then the third one would go out. And then if a case came, called in again, and we were all out, then we used to have to ring in to headquarters, and they would find somebody from somewhere to get up and come over. Happened to me many times.

You were dealing mainly with Type 2 diabetes, I guess, in the elderly. Had you had any specialist training for that?

No, we just took it as it came.

Can you remember receiving any training regarding changes in diet for diabetes, or changes in care for feet or eyes?

Well, of course, we got that in our general training, because we were taught how to care for diabetes right from the beginning, so, you know, it was a gradual learning streak, really. And, occasionally, there used to be a course to update us in something new, and very often diabetics used to come up, so we would get all the new stuff that was coming in.

(16) Tell me a bit more about this annual diabetic evening for all your patients with diabetes.

Oh, well, this was quite a highlight in the year, because Professor Malins used to come out with his team, and we used to see all our diabetics in the surgery. All those that were able to come all turned up, and they had their urine tested and their blood pressure taken, and bloods taken, and anything that was absolutely necessary. And they were seen and advised, and told when to go to the hospital,

because in the meantime, between each of the big visits at the surgery, they used to attend the hospital to Professor Malins' clinic there. So, he knew all the diabetics extremely well. But we had some diabetics who couldn't come - they were housebound. So, bless his cotton socks, he used to take his team out with him to all the houses. And I remember talking to him one night, and I said "you must find it very tiring". He said "I love village work, and so I'm taking my team"! And he did; he used to visit all the diabetics that were not able to come. And then, when he'd done that, our lady GP used to go home and prepare a great party for us, which used to go on till about midnight; it was great. So, everybody used to look forward to the diabetic clinic once a year with Professor Malins!

Did his team include a dietitian or a podiatrist?

No, not in those days, it didn't. The dietitian was at the hospital, because my mother was a diabetic, and she was under his care, actually. And she used to see the dietitian there, but I don't think she ever got her feet checked. But she was a late diabetic. She was in her late sixties when she became a diabetic, and I remember I was horrified to think that my mother had become a diabetic, after all these years of treating them. And the district nurse had to come in; very independent my mother was. I used to give - because I lived near home at that time - so, at the weekend, I used to say to her "well, tell the sister that I'll be home at the weekend, so she needn't come in to give you your injection. I'll give it". Well, I don't know whether it was my giving the injection or sister giving the injection, but my mother suddenly decided that she didn't see why she shouldn't give her own, and she did until the day she died; very good.

Can you remember what year your mother got diabetes?

It was while I was working on the district. I remember diagnosing my mother, because, of course, having dealt with so many of them, when she started to tell me how she didn't feel terribly well, I said to a friend of mine, who was staying with me at the time, "I'm sure my mother's a diabetic". So, I made her go to the doctor the next day, and sure enough... oh no, I tested her urine. I said "give me a sample of urine", and, sure enough, it was absolutely loaded with sugar. So, how long she'd been a diabetic for, I really wouldn't know. But that was about... I suppose it must have been about 1968, probably, '69, because she died in '73.

(17) So, looking back on when you first encountered patients with diabetes in 1940, and when you retired in 1982, what were the most striking changes?

Well, of course, first of all, the most striking change is the number of insulins that there are now. I mean, I'm not up to date with insulins, as such. I have a friend who's a diabetic, and I just sort of vaguely keep up to date with her. But I know that there are so many insulins available now. And when I compare with what we had, which was soluble insulin and protamine zinc, and that was all we had to work on. And it wasn't always easy to balance it, to get a patient, for instance, out of a coma. In that respect, life for the diabetic is very much

easier. The other thing, of course, is diet. We had to be very strict about the diet, in every way. During the war, the patients who were in hospital, of course, were looked after diet-wise, because it was so much easier to do. I was trained in a thousand-bedded hospital, which was a vast hospital in those days - not compared to what they are now, but it was vast - and so the diabetics could have the kind of food that was necessary for them. But now, of course, from what I understand, they eat pretty well a normal diet, providing they take their own blood at the right time, and adjust their insulin accordingly. And, in some instances, they're giving insulin twice a day. My friend is; she gives it to herself morning and evening. But, from what I see of her, she seems to have a pretty normal diet. And this goes without saying, I think, to most of the modern diabetics now, so their life is very, very much easier. The other, of course, thing is feet. We were trained... because we were trained to look after diabetics right from the beginning, and feet, of course, were one of the important things we had to deal with. If we saw any change at all, a changed colour of toe nail or foot or toe had to be reported immediately, because, invariably, it was a gangrenous thing. And once it started, in those days, it just didn't stop. And I have seen quite a few amputations up to the ankle, then to the knee, and then to the thigh, simply because the gangrene was creeping up, and they didn't seem to be able to stop it. Now you don't hear very much at all. Unless a patient does not look after themselves, and does not keep an

(18) eye on their feet themselves, then you don't hear of very many amputations at all. And the... all the chiropodists are geared up and trained specifically to look after the diabetic feet, and as soon as they see anything going wrong, immediately it's reported and dealt with straight away. So, the life of a diabetic, I would say, forty years on, is almost a normal life, except the inconvenience of having to take that little bit extra care of themselves.

But you've talked about knowing all your patients very well. Did that continue right the way through to when you retired in 1982?

Yes. On the district, of course, things were different in time stay. In hospital, patients come and go; they do. They only come in for a short time and then they're out. They didn't come in for as short a time as they do now - I mean, I think they're in and out before you even see the patient, these days. But on the district, the patient was coming home to whatever their problem was. It was to be looked after at home for the rest of time. So, you had your patients a long time - I mean, until they died, very often. So, you got to know your patients extremely well. You got to know the family; you got to know what their problems were, if they had any. And you were able to help in many ways that you couldn't help in hospital, which is put them on to the right areas to deal with the problem that they had, or to get in social services to help you nurse them better, or to get in touch with the GPs if they wouldn't. And, particularly in diabetics, to keep a very special eye on them, and see that they went to the hospital when they should have done, and gave their insulin. Or, if they were giving it themselves, you went in regularly to check that they were and they

weren't getting the dose wrong, because you'd make the patient, or least ask the patient to draw up the insulin that they were giving, and you'd check that they were giving the right dose. So, we did see our patients longer, and we did get to know them better than when we were in hospital. And it was a nice life; I enjoyed it.

And is it your impression now that people with diabetes get that kind of personal care?

Well, I've been retired twenty years, so things have changed, and I only know what I hear. And it seems to me that sometimes - sometimes - care falls rather short of what I think it should, but that's only my own personal opinion as a craggy old, retired district nurse!