

68. Dr Irene Bainbridge

(1) Tell me about your background.

I was born in Florence, in Italy, in 1935. My parents... my father came from Poland - via Palestine, as it then was - because there was no future for Jews in Poland, at that time. And he worked on the land, and founded kibbutzim; got malaria, typhoid. Then he heard that Mussolini was offering free education to all, and so he took a boat - with his little hat, and a few notes inside it - and came to Italy, via Naples, speaking Latin, not Italian. In Palestine, he had been speaking Biblical Hebrew, rather than modern. And he went to Florence, and he joined quite a sizable group of Polish, Jewish young people, who had come to study there, which is a very interesting group, actually. And he met my mother there. And she came from Gorizia, which is in northern... north eastern Italy. And it's always been a frontier town, and they always joked that they were both born in the Austro-Hungarian Empire, so their education was very similar. And the language they had in common, apart from Italian, was German, because they had all had to learn German at school, and quite a lot of the customs of Franz-Josef and the Empire. And anyway, in that background, my brother and I were born in Florence. And we had a very happy time there, until suddenly, 1938, the racial laws were announced: Mussolini had joined Hitler, and all Jews were dismissed from government; I suppose they were government posts, university posts. My father had risen very rapidly to a Chair in organic chemistry, under Professor... he had studied with Professor Angeli, who was a very distinguished organic chemist, at the time. So, having to leave Italy: he saw, instantly, that the writing was on the wall, and that we should leave - all of us. And he came to England, hoping that, perhaps, he could get to the States. But when he got here, the people he had met - various academics - asked him to stay, and he sent for us. And that was the start of our childhood here, in England. And my brother and I quickly became very English. I learnt English from him, and we brought English home, and taught our parents how to speak English properly - as it should be spoke!

(2) How old were you when you came to England?

I was three and a half; my brother was six and a half. And we... I remember a very awkward occasion in a nursery school, when I couldn't speak a word of English, and couldn't even ask to go to the toilet, and I won't tell you what happened! I was glad to get home, and vowed never to go there again. But later on, we soon joined in with everything that was going on. And we were bombed out, in London. My father was interned on the Isle of Man, along with enemy aliens. That's a whole chapter in itself. And then we moved to Manchester, where the bombing was equally fierce. But with the help of the - I don't know if you want to hear about this - the Morrison shelter, the table shelters. We had a huge one, which occupied our living room, and it was covered with a blanket. And we did our homework there, we played on it, we slept underneath it, we hid there during air raids. It was a wonderful thing. And those were the war years we spent up there, not really aware of what was happening to my father's

family. We sensed a lot of anxiety, but he tried not to let it spill over on to us. It was - now, looking back - I think it was quite marvellous that we didn't get to feel these anxieties, these horrors that were going on, until afterwards. We understood, afterwards, why he was so ill at the end of the war, when he knew that they had all perished.

Tell me about your secondary education.

Well, I got a scholarship to Bury Grammar School for Girls, which was a lovely school in a mill town. And it was a marvellous time, there. And I loved sport, and I was games captain, and played everything - mainly tennis - and I did a lot of tournament tennis.

When did your interest in medicine develop?

My brother entered medical school. And all along, my father thought that girls should have a sheltered life, and said "don't worry about your exams. If necessary, you can just go to the... just do some botany, or something to do with sewing and cooking"; domestic occupations! But they could see that I wasn't going to do that, and I decided I would do what my brother had done. And also, my father's brother was a doctor - a radiotherapist - who had studied in Florence, also, and he was now a radiotherapist in this country. And so, medicine seemed a good choice. I was interested in the biological sciences. Not very good at physics! My brother got me through that, and my father helped me with the chemistry, and I just took the medical course. And I hadn't even applied to St Hilda's. I was going to go to Manchester University, but the Dean said that I was too young, and I would have to apply the following year. And the following year, my brother suggested I should apply to St Hilda's, and I did. And so, to my surprise - because there were not many people going from northern schools, at that time - I got a place. And I was very happy with that.

(3) Tell me about the medical course at Oxford.

The medical training at Oxford was excellent, I can say. I can say that, looking back now, how wonderfully it prepared me for what came later. And we had some marvellous teachers; some very eminent. We probably didn't realise, at the time, quite how eminent they were. There was Le Gros Clark, Alice Stewart, Honor Smith. Should I tell you what their specialties were? I mean, Le Gros Clark was the anatomist; Alice Stewart was a dermatologist, who drilled us in anatomy; Honor Smith did a lot of work in TB meningitis in children. Sir George Pickering - later Sir George - Professor Pickering had just come from St Mary's, with his retinue, and we were his first students at the Radcliffe Infirmary in Oxford. And that was a great privilege, and it was great fun too. And we used to have seminars at his home. He often took to his bed, because he suffered from gout, and we would gather round his bedside, and have our tutorials there; just three or four of us, a little group. It was very intimate, really. And his wife, Carola, was very welcoming. That was Norham Gardens; 13 Norham Gardens. David Pyke was our medical tutor, and he instilled in us the need always to examine the patient. "Always undress the patient and examine them. You don't

know what you'll find, until you look". Harold Ellis was the surgical tutor - later Sir Harold Ellis - and he was very witty. And the thing that we remember most about his sessions was "always empty your bladder before you start on a surgical emergency, because you may not have time, again, for several hours to do that"! And that's always stayed with me. And Sam Corrie was the surgeon I worked for in my first house job. And he was very kind to us. I should mention that I met my husband in the clinical course. He came from Cambridge, where they didn't have a clinical school, at the time. And so, he was one of the outsiders. But we were a very small group. I think there were eight of us in the intake to the Radcliffe Medical School - that was 1958 - and, of those, there were two women and six men. And that was approximately the ratio; perhaps less in some intakes. There were two intakes in the year, making sixteen altogether, at that time. So, we were very, very privileged to have the teachers to ourselves, pretty well, and we did a lot of hands-on medicine, at a very early stage.

- (4) Can you remember what you'd learnt about diabetes, before you began the hands-on medicine?

During the pre-clinical course, diabetes was part of the biochemistry. And, of course, we had Sir Hans Krebs, of the Krebs cycle, who would just talk to us, and listen to our views. And, over a cup of coffee, we would share ideas about the cycle, and about metabolism, and we would talk about diabetes. And it was a metabolic disease, in our eyes, at that time. And then, as we came into the medical school, and did the clinical work, and actually saw patients who had diabetes, we realised what widespread implications it had, for their families, and in their lives, generally. That was the big impact of clinical medicine: actually seeing, in real life, what the theory was all about.

Can you remember what the orthodoxies were, regarding treatment, at that time? We're talking, as you said, 1958.

Not very much, actually. Just... there was insulin, and there was treatment with diet, and maybe there were some tablets. I don't remember much about tablet form of treatment.

Were you talking about Type 1 and Type 2, or not?

No, we were not. It was rather strange, really. Diet seemed to feature very largely, though, in those days. And I remember the feeling that patients felt they had, in a way, brought it on themselves, by eating the wrong foods, and having too much sugar and carbohydrate. And they had to cut this out, very severely, from their diet. So, dietitians were very, very important people. And that was... And the insulin injections were very difficult. And when there was some kind of crisis, and the patients were admitted to hospital, they stayed in for a very, very long time. I mean, they'd stay in for weeks and months, really. I remember some patients, on our first clinical firm, who were there throughout the six months that we were there. And I can't really say why they were in so long, but that was the way it was done. And stabilising diabetics must have been exceedingly difficult, because they were pretty well in bed, most of the

time. In fact, everybody was in bed; I don't remember people sitting out of bed, even. I don't know whether deep vein thrombosis was a big problem. I know pulmonary embolism was. As Dr Rob Smith - who was the pathologist, at the time - pointed out, that in the temple of ultimate truth, we discovered what pathological processes had actually been taking place.

- (5) So, that was what I remember about diabetic care. Dr Cook was the specialist, who was particularly interested... A very kind man; he was very kind to patients, and to students. And everybody looked forward to having sessions with him, or to being on his firm. I did do a locum on his firm, one time. But he did see general medical patients, but his special interest was in diabetes. But I'm afraid I don't remember very much about how it was managed, apart from these big crises that occurred every now and then.

Can you remember how glucose was monitored?

It was, as far as I can remember, it was entirely venous blood samples. And certainly, patients didn't check their blood sugars at all, but they did a lot of urine testing.

You mentioned that some of the patients felt that it was their fault they'd got diabetes. What were the attitudes among medical staff?

Certainly, as a student, one got some very definite impressions of the attitudes of our teachers to patients and their diseases, which varied to a certain extent. But there were certain things that were fairly common, I think, such as, perhaps, emphasising the - I suppose we still do it now - emphasising that people's lifestyle does have some connection with the illnesses that they're suffering. Not always, of course, but this came over very much, then. And that would be the case with diabetes, and with obesity, and obesity-related conditions.

- (6) And then, how much you told the patient: that was another thing. This particularly showed up in the surgical specialties, where patients would need to have explanations of why they needed an operation, or some medical intervention. And I remember we felt that we shouldn't tell the patients too much. One had to speak to, perhaps, a relative - a responsible relative - but not tell the patient. And that was rather strange, and it did seem strange to us, as well. And sometimes, there were some very nasty things that had to be told. But, on the whole, the patients were shielded from these, and perhaps a wife, or a husband, a spouse, a parent - somebody else - would be told. And then they had the task of dealing with it, and somehow transmitting to the patient what they had to do, but not actually worrying them with a bad prognosis, and such things, and trying to answer patients' questions. But patients didn't seem to ask questions, then. They didn't seem to feel that it was their place to ask. They were afraid to ask, perhaps. But one or two of our teachers did have a rather brutal approach, and perhaps it was a reaction to this not telling the patient. They obviously felt that the patient should know, but they

didn't know how to transmit the information, and would say "I'm afraid you've got cancer of the bowel, and you've only got a few months to live". And that would be it. And we thought that was quite dreadful, but that was the way, at the time. Others, perhaps, put it in a slightly different way, but I remember we were... we often had discussions about this, among ourselves, and thought it was really not something we were happy about at all.

Do you think that patients with diabetes would have been warned about the possibility of future complications?

I'm not quite sure that the whole range of future complications was realised, at that time. I certainly don't remember patients being warned that... about the extreme seriousness in the long-term. They would be told that they might have short-term complications, or they might have diabetic coma, or hypoglycaemia; they would be warned about those. But I don't remember fundal examination, at all, or neurological examinations.

Can you remember any chiropodist being around or any eye examinations taking place?

If there were, I'm afraid I don't remember if there were.

(7) Any more memories of the wards in the 1950s?

Oh, yes. I mean, on the whole, they were - in the Radcliffe - they were long wards, with about twenty or thirty patients, beds side by side, surrounded by curtains, which made privacy extremely difficult. And when taking, as we did, clerking patients, if they were slightly deaf, we would have to shout the questions. And some of them had these big ear trumpets that we would have to shout into. And all the surrounding patients would be absolutely laughing their heads off at some of the questions, if they were well enough to laugh. We were very embarrassed, of course. And the sister ruled, in the ward. The sister of every ward was an extremely important person. She knew everything that needed to be known about the patients. She would tell us if we could come in, or not, and so on. It was very important to get 'in' with the sister, in the ward! Then there were the ward rounds - the grand rounds, as they were called, and probably still are, in some of the big teaching hospitals. But they certainly don't take that form in outlying hospitals - which do quite a lot of teaching, nowadays - as in our local hospitals, here - district hospitals - in Colchester and Cambridge. And they were very formal. There were large numbers of people - perhaps even fifteen, twenty people - surrounding the bed, with the senior surgeon or physician taking the round, and putting all the little medical students on the spot with difficult questions about the history and diagnosis, treatment. And the patient would lie there, being talked about, and would simply just keep quiet, and would hardly be referred to at all, in person, as if they were just a lump of lead! It did strike us as very odd, really, and not something that we really felt was the way we would want to conduct our relationships with the patients. But that was the

way... the example we were given, and I'm afraid it probably did colour a lot of people's attitudes and behaviour for quite a long time.

You mean the students' attitudes and behaviour?

Yes, after they became doctors, and seniors themselves. It probably took quite a while - several... maybe a generation of doctors - before things changed, I think.

- (8) Also, as part of the teaching, we had lecture demonstrations, in which a patient would be brought - wheeled - in, in their bed, into one of the large lecture theatres, in front of about fifty or sixty assorted medical students, consultants, housemen, et cetera. And a student... we would have turns at presenting a case - presenting the patient's case - and discussing it, and answering questions about what was going on. A very daunting experience for anybody, and not a very pleasant experience for the patient, I should imagine. The one that springs to mind - the demonstration - which took place every week, was called the Wittery. And it was organised by Professor Witts, and his team. And one would have to prepare for this, and you always knew your turn was coming, and you hoped that they would be merciful. Another strong recollection that we have... I say we, because I'm talking about myself and Douglas, who was a medical student on the firm at the time, and later became my husband. We still laugh about it now. It was in an obstetric ward round, when Professor Chaser-Moir was demonstrating something with a pregnant lady, who was in bed. And he wanted to elicit her plantar reflexes, but she insisted on keeping her feet plantar flexed, because I think she felt it looked a bit better. And he got quite annoyed, and he said "don't point your toes at me, woman!"

And any more memories of the outpatient clinics in the 1950s?

Most of the outpatient clinics we attended were in the afternoons, when we were experiencing postprandial lows. And I remember sitting and waiting a lot, and I think the patients sat and waited even more. And the waiting halls were crowded. There were people sitting on benches all around. I don't know how the appointment systems worked. There must have been an appointment system, but teaching obviously took up some time. And... Actually, we did get to examine patients, to see them in the cubicles, but it was all a bit chaotic. And very often, they were held... patients were being reviewed by junior staff, whom they hadn't seen before, and did complain quite a bit about it to us medical students. They often unburdened themselves to us, where they wouldn't, perhaps, to anybody else. And they felt that they were seeing a different person each time, and that they had to repeat their history, and that the notes were missing. I don't think anything much has changed.

- (9) What did you do when your training ended?

Then I... then it was time for house jobs. And I did a surgical house job, in which we had a one in two rota, which meant that we would be up for the best

part of the night in theatre, and seeing emergencies, and having to work the whole of the next day. That was quite the usual thing. Because it was a one in two rota, there was just the chance for catching up on sleep one night. But most of the jobs were actually single people - one person - doing the house job, and no chance of any respite at all. Occasionally, one might be able to get somebody to cover, but that was quite rare, and quite difficult, because, well, it was very difficult for somebody to cover for neurology, if they were doing ENT. This did happen, but rather reluctantly, but only, really, just to keep one sane. So, it was a very punishing rota. Also, the living conditions were quite appalling, by today's standards. I don't think anybody would put up with it, now. But a lot of us had really very dingy rooms, with maybe a broken chair, a table lamp that didn't work. None of the mod cons of modern living at all. Shared bathrooms, perhaps on a different floor. And as for married doctors doing house jobs: it really was frowned on. And we had married, just before starting house jobs. And I remember what a fuss there was about having a double bed in one of the housemen's rooms. And this had to go through administration, and there were meetings about it, and we only managed to get it done with the support of Mr Corrie, my surgical chief, who said it was all utter nonsense. But that was the state of affairs. And others, who had spouses who came into the housemen's rooms, would stay part of the night, and then they would leave in the morning before the cleaners came in, so that this shouldn't be generally known, because there might be trouble if it came out. They really had to slink out of the buildings.

(10) What did you do next?

Well, we were married in 1960, and our first child, Simon, arrived in 1961. And then Douglas had house jobs in Southampton, so we moved there. And he had to be on call five nights on the trot. And so, all I remember was that he would just come home, at the end of five nights, and sleep, solidly, before his next turn of duty, after one day. Then he'd be doing another five nights. So, that was a short spell in Southampton. Then we moved to Mill Hill, and we had two more children. And during that time, I was really... would have liked to do some more medicine, but the opportunity just wasn't there, because part-time jobs were very, very scarce. I wasn't fully registered. I had done one and a half house jobs, and one had to do a surgical house job and a medical one. So, I needed to do that. So, I became interested in marriage guidance, and I was selected and trained by the Marriage Guidance Council for individual counselling, and also for educational work in schools and youth clubs, which I loved. I was called the Sex Lady, and went to schools and did little groups, just discussing sexual health, sexual issues. And that was very, very... a very interesting, fascinating time. I did that for about ten years, and that was at Barnet, Haringey and South Herts Marriage Guidance Council. And that was a very good background, actually. I found that very useful, afterwards; the counselling techniques.

(11) Then we moved to Heddingham, out here in Essex, because we needed more space. My mother had come to live with us, and the boys were

getting bigger, and their friends were coming to stay. And here, we found lots of room. It took quite a bit of adjustment to country life. But the opportunity then presented itself for me to go back to medicine. I had a French cousin, whose friend had a daughter who wanted to improve her English, and did I know anybody with young children where she could learn English, and help in the house. I couldn't think of anybody, and then suddenly, I thought, what about us? And that was the start. She wasn't a very good au pair, but I got going, and I joined local hospital ward rounds, and made... got myself into some of the medical events in this area. And it was a time when they were seeking to recruit women, who had been wasted, to medicine. So, really, I was very fortunate to start coming back in at that time, and I jumped onto that bandwagon, and managed to get a supernumerary post arranged - with some difficulty; it wasn't easy. But, however, I had a very supportive family, and quite a lot of support from local consultants, who had seen me appearing regularly on ward rounds. And I got the job in Broomfield Hospital, and it went on from there. I got a series of house jobs. And it was such an eye opener, because I became aware of the huge changes that had taken place, not only in society, but in medicine itself.

(12) After how long a gap?

That was a gap of... what was it, from 1962 to '72; a gap of ten years. And my goodness, it... People asked me: how did I manage to deal with the medicine, the changes that had taken place in the medicine. The medicine, itself, was not difficult, because, somehow, I found that the training, the basic training that we'd had at the Radcliffe, was so good that, if one really stuck to taking a good detailed history, and doing a proper physical examination, things would fall into place. Treatments had changed, but one could quickly pick up on the ways that diseases, conditions, were managed. But the actual length of stay in hospital, and attitudes, had changed radically. And people were whizzing in and out of hospital. They'd stay in for a few days, have tests done, sort things out, start on treatment, and off they went. And particularly for diabetes, this was very, very important. It was clear that it was much preferable to stabilise a patient in their normal working conditions, and their living conditions, than to do it while they were lying in bed, doing nothing. And also, the part that they could play in the management of their condition had changed, and there were blood monitors they could take home and check their blood sugars. And the emphasis on urine testing diminished rapidly. It was still being done, at that time, but I've seen it gradually phased out, over the past twenty years or so. I'm not sure at what point the blood monitors came in, but they certainly were doing some finger-prick testing - at least by the nurses, if not taking over the testing themselves. So, that was very interesting. And the sliding scales were very much used, where the insulin levels would be adjusted according to the blood sugar levels, over the first few days after admission in some kind of crisis. And then the final fine-tuning would be done at home, during normal life.



- (13) Now, on reflection, you think that the gap away from medicine was a little longer than you said?

Yes, I've probably got the years a bit garbled. '61 was the birth of our first child, and I had stopped working at that stage. And then I was out of medicine until after we got to Hedingham, and our au pair was installed. And that was 1974, when I started going on the ward rounds.

So, we're talking about a period of thirteen years away from medicine, and those were quite crucial years of change. What other changes do you remember?

They were, obviously, crucial years. And I wasn't even reading medical journals during that time. I didn't have time, apart from anything else. So, when I was doing the house jobs, I really did take the plunge. But it was all extremely interesting, and didn't seem difficult, somehow. And with the diabetic care, particularly, I mentioned that the patients were stabilised during activity; they weren't in bed any more. I should say - emphasise that - that, really, bed was considered a very dangerous place to be, because the connection with deep vein thrombosis had been firmly made. And so, patients had to drift around, and walk about, and spend their time in the day room, and in the corridors. And they were simply not allowed to sit still for more than five minutes. They were kept on the move all the time. So, that made diabetics' stabilisation much more realistic. And then, when they went home, it changed again, because their diet changed as well. That was the interesting thing, too, that the role of the diet changed, too. And now, the emphasis was gradually shifting away from the strict diabetic diets that we had known in my first medical phase, and now was going on to more... a wider range of foods, than previously. Though that, I've seen change again, over the past twenty years, so that now, diabetics are allowed to eat - I say allowed - are encouraged to eat practically everything that the rest of their families are eating.

- (14) Now, the other thing was the education of diabetic patients. They were really drawn into their care so much more than previously, and became... were helped to become quite knowledgeable about their condition. And there was this marvellous organisation - the Diabetic Association - which was one of the first things they were told about. And many would get a lot of support from that, and learn about new methods, new techniques, or appliances that could be used, and would sometimes be the first to come and tell us about them, which was very, very helpful indeed. So, that was a big thing. And then, in came the insulin pens. And... now, that must have been in the 1980s, when I was a GP. I had my own practice, then. Yes, I got my own practice, then, in 1978, in a village quite near where I live. And then, in general practice, you really live with your patients, as it were. And you see them from time to time, and they keep coming back, so that you know what's happening to them. And, although you may not tell them everything, or discuss everything the first time you see them, there are so many opportunities to reinforce messages and to clarify things, and patients can come back and ask questions. We appointed a

Diabetic Specialist Nurse, in the practice - way back in, I suppose, 1987, something like that - who became so knowledgeable, really, and was seeing most of the patients soon after diagnosis. And would have a session, and go through a checklist with them of all the things that they should look out for and they need to know. And they would be reminded that they need to go to the optician, and to see the chiropodist, and to write down and check their blood sugars. But it would be tailored, obviously, to individuals. But we did make sure that the patients knew quite a bit about how to manage things.

- (15) Before we talk about the 1980s in any more detail, tell me about your practice, as it was when you arrived in 1978.

I was very fortunate to be offered a partnership in the local practice, about a mile from my home, although it did mean that you kind of lived on the job, really, and took work home; though, I suppose I was fortunate in being able to cut off from work and do family things as well. The senior partner was a delightful person, who had been in the Royal Navy. And he said that, if he hadn't been a doctor, he would have liked to have been a plumber, and that plumbing was very easy because it's just like Lego! Now, he didn't talk a lot, and his writing was pretty well illegible - as seems to be expected of GPs. And when I came to the practice, patients would tell me about him, because I came with great enthusiasm and new ideas, of course, as one does. And I would say "well, there is a treatment for your condition, now, that we could try". And they would say "Oh no, no. Dr Veater said that I'd never recover from it, and that I'd have to live with it, and so I do". And they did, and they didn't want to change things. And they had adjusted to the situation - didn't want to try anything new. I learnt a lot from him, about how to manage things in general practice. It was kind of intuitive medicine. And he would tell people, he would say "you're going to recover, but it's going to take a long time. It's going to take about seven weeks". And they would say to me, with wide eyes, "do you know that, by the sixth week, I could feel that I was getting better? And it took exactly seven weeks for me to get completely well". And then they would say "he saved my life, you know? He told me that there was something wrong with me, which I knew, but I didn't know, at first, whether it was serious or not. But I could tell from the look on his face..." And then they would go on to say... either they would say "I could tell by the look on his face that it was all right", or sometimes they would say "but I could tell it was very, very serious, and very bad, because he would get all hot and bothered, and he scribbled things very fast, and didn't look at me. And I knew that it was something bad". And then they also said things about the certificates. "I need a certificate, please, doctor." And when I wrote out what they were suffering from on the certificate, I remember one young man looking at it, very critically, and saying "but I can read this"! And I'd say "yes... ", and he'd say "well, when Dr Veater wrote it, you couldn't read what was wrong with me". And that's what he wanted!

- (16) Any more memories of the practice, in the late 1970s?

Well, it was a rural dispensing practice, located in a village, in a sort of outbuilding attached to the principal's house. And the waiting room was a tiny space at the front; then there was a tiny office; then the consulting room; and then a pantry at the back, which was the dispensing area. That's it. Absolutely minute, the size of a garage, more or less, the whole thing.

And just two doctors?

And one and a half doctor to begin with, and then we were two doctors. And dispensing in a rural area is very, very important, because it means that it's a one-stop shop. The patients come, the problem is diagnosed, and treatment can be started straight away, dispensed there and then. They go home with the medicine, and with instructions on how to take it. And if there are problems, they can come back and report any side effects, any difficulties, and things can be dealt with. And, of course, the patient's history is known to the doctor; their other medications. And this was a very interesting part of the practice, and something that I hadn't come across before; this very close contact with the actual medications, what they looked like, what they felt like, and how they were to be taken. And this is particularly the case with diabetes. I remember, because we had a special fridge with temperature... with the thermometer, and we had to give instructions, to the patients, on how to keep their insulin, and how to manage their injections. At that time, there were disposable needles. That was another thing that had come in, in the meantime, over those years when I was out of medicine. Everything was disposable, then. So, that made things much easier, too. But, of course, special care had to be taken with disposal of the needles, and that was part of the instruction that the patients - the diabetic patients - had.

(17) How near were you to a hospital?

Well, our nearest district general hospital was twenty miles away. In fact, although we live - as people say - out in the sticks, we're in the middle of an area which has one, two, three general hospitals, but they're all at least twenty miles away. One of them is thirty miles away. So, one has, in a country practice, to deal with things on the spot, and to have the necessary equipment. And this included carrying emergency kits. And I had... I carried in my car - each doctor has a different way of doing it - but I carried, in my car, little boxes labelled in large letters, which I could read even in the middle of the night. And there was my diabetic... There was one box which was hypos, and the other box which was coma. And the hypo box, initially, contained very, very large vials - twenty ml vials - of glucose solution, and large, huge syringes. And in the case of a hypo, one would have to be able to administer this slowly, intravenously. Now, of course - did I mention? - over the years, this has got smaller and smaller, and now we have a nice tiny Glucagon injection kit, which is neatly packaged, and easy for patients and doctors to carry about.

What was in your coma kit?

Intravenous drip equipment. We had to have that, really, for all sorts of situations.

So, that was very useful to have.

- (18) With this long distance to the nearest hospital, what was the relationship between general practice and hospital treatment?

Well, of course, we did all our own emergency work, and so that would be twenty four hours on call. We had a rota with another local practice. With the long-term management, patients would be referred to the diabetologist at the local clinic. Of course, there wasn't always one, but there was usually a physician who was interested. . . had a special interest in diabetes. But all the physicians would have diabetic patients; certainly initially. And they would go for the first clinic - the first outpatients visit - and then they would be recalled, regularly, to do checks; routine checks. I can't remember at what stage HbA1c came in, as a measure of diabetic control, but it must have been early in that phase, soon after I came into general practice. That was a new thing. And we did. . . we saw the patients sporadically, in practice, about all sorts of other things - not about their diabetes. Of course, I mean, diabetic patients have problems just like everybody else; other medical problems. And pregnancy was something that we had to manage very carefully, also with the help of the hospital. But most of the management actually goes on at home, and in practice - in general practice. And so, we took really, special care of diabetic pregnant women - saw them more often than the others.

- (19) When do you feel that the balance shifted, from patients going mainly to the hospital for their treatment, to mainly to the GP?

I suppose it was actually beginning to shift in the 1980s. And certainly, out here, in a more remote rural practice, with very poor transport, people were really quite unwilling to go to hospital when they felt quite well. And they thought they just needed a check-up, and really didn't see the point of going all that way. And a lot of GPs were really taking quite an interest, anyway, in progress in diabetes, and so quite a few practices were beginning to do it themselves, and to do quite a lot of the follow-up. Certainly the education was going on, and the dispensing, so we knew what people were needing and taking, and how they were using it. We got very close, really, with our diabetic patients, and this was a gradual process. Another factor was that we were diagnosing more diabetics, and the hospitals were not really able to keep up and cope with the increasing numbers of diabetic patients being referred. And so, they would. . . really, they asked us not to refer them, so often, and could we, perhaps, see them in between times, and they would just maybe see a patient once a year. And that seemed a very good arrangement, because we became much more familiar, then, with diabetic care, which was a good thing all round, for everybody. And other healthcare workers were becoming involved in the diabetic team. There was the local ophthalmologist who. . . the local optician, I beg your pardon, who would be able to take a special training in fundoscopy, and would work hand in hand with us, and we would have good communication. And the district nurse and the practice Diabetic Specialist Nurse, who would go on courses and have extra training, and become very expert. The chiropodist would be part of our

team. A lot of chiropractors were working... began to work in practices, towards the end of the 1980s. So, when the new contract came in, in 1990, there were special inducements to practices, to encourage practices to do more, because there are considerable resources required to do this. It's not something that can easily be undertaken, without extra expense of more staff and premises. And I can't remember what it was - I mean, it was very minimal, actually; very small financial inducement - but the emphasis was there. And if there was an interest in the practice, this was... it gave new blossoming of extra work on the subject.

- (20) And I remember that we started using a computer, round about there. And the diabetic register was something that I was very interested in, in our practice. We were making disease registers before the contract. In fact, the contract really reinforced what we were already doing. And we were collecting the names - this was all on... initially, it had been on cards, and we were transferring it gradually to the computer. And Douglas, my husband, who's very good with computers, helped me to make out a kind of checklist of things that we would want to know at each check-up, which included whether there had been any hospital admissions during that time, and when was the last blood pressure date, and level of last blood pressure reading, cholesterol level, and HbA1c at the last reading, and a checklist, again, whether any neurological complications had been identified, or fundal examination. We had it all in a very user-friendly form, so that it could be transferred into the computer quite quickly by, not just ourselves, but by the practice nurses. And that became - gradually - became part of most computer practice programs, but we had already made our own, initially, so that was quite a nice, useful tool.
- (21) You mentioned that one of the things you would want to know, for the records, was whether or not they had been admitted to hospital, since their last visit to you. Would you not have been informed by the hospital of that?

Well, we should have been, but I'm afraid to say that we weren't always. At the most, we might get a little slip from the admin section of the hospital ward, to say that the patient has been discharged on such and such a day. But that might arrive a week or two later, and, very often, the discharge letter, as it was called, with details of the admission, would be held up. I know that they did have a lot of secretarial problems in the hospitals, and just, somehow, the communications often broke down, for these reasons. And the first thing we knew that the patient was home might be that they came in for a repeat prescription, or something that had been advised in the hospital, and started in the hospital. And we didn't always know what it was, or what dose they were supposed to be taking. And sometimes - not in the case of diabetes, particularly - but sometimes with the - it doesn't happen now - but at that time, with some of the oncology patients, who were on very new drugs that we weren't familiar with at all, we didn't know anything about the drug, and side effects, and dosage, and regimes. And we would have to spend time phoning the hospitals to find out. That was really

very unfortunate. And it's happening, I hope, less often now.

(22) Can you tell me a bit about what kinds of patients you had with diabetes?

Yes. Some of them really seemed to stand out in one's memory, somehow. I think, largely, because... the ones, particularly, who had very nasty complications, or the ones who were particularly difficult to control, or were in and out of hospital a lot. And then some difficult diagnoses. Quite a few of the elderly diabetic patients were, for other reasons, had become housebound, and they were really quite old, and didn't - when I first came into the practice - didn't come to the surgery at all. We did a lot of home visiting. I used to go... I mean, it was actually very... a privilege, really, to see people in their homes, on their own ground, and to see how they lived, and to be allowed to see how they lived. And they seemed to jog along. I do remember an elderly man - a widower - in one of the cottages in one of the outlying villages, who just sent up... sent the niece along for his prescription. And he was always so delighted to be told that his diabetes was well controlled. I remember how pleased... I think he considered it was that he had done very well, that he had tried very hard, and it was partly his success, in a way, that he... And also, very grateful that he was being looked after, being treated, cared for. He did extremely well. I think he lived into his nineties, and didn't have any serious complications at all.

Was that non insulin-dependent?

Yes. And then, there was one patient - I could just see his house now. He was actually a blacksmith, and made beautiful wrought iron things, which can be admired all round the countryside, all over East Anglia. And his mother had had diabetes, there was a strong family history, and he gradually developed... And despite very careful checking, he was rather unstable, his diabetes was brittle. And he spent a lot of time in and out of hospital, even though he was very conscientious with his check-ups and medication. And he developed quite a lot of complications, but somehow survived at least... he was in his late seventies. Didn't do too badly, considering how many admissions he had had. But his eyesight had practically gone, and so he couldn't go on doing his work. But he went... he did a lot of dancing, instead! So, it was quite good to see how he coped with a very difficult condition to live with.

(23) And then a very well educated lady - I think she was a lecturer in one of the local universities - who really was, in a way, denying her condition, and kind of pretending that there wasn't anything wrong with her. But she had to have one leg amputated, and had all the trouble with the prosthesis, and then her vision was going. And she wasn't, I'm afraid, very good at coming for check-ups; we had to chase her a lot. And I could see why, because she didn't want to know. And this was the condition with some of the young diabetics, the very young - those diagnosed in childhood, or in their teens. I remember two, particularly. Her mother used to bring her, always, to the surgery. And she was insulin-dependent, and didn't want to follow any diabetic regime at all, and wanted to do everything

that her friends were doing in their teens, and go to the youth club, and stay up late, stay out late, eat irregularly. Didn't always have... get home in time for her injections. It was a bit of a disaster, really. And then she was on the... she had been given the oral contraceptive pill, and that was a disaster too, because she had myocardial infarction, in her late twenties. And then a lot of things went wrong for her, and her vision deteriorated a lot.

- (24) And another adolescent, who had very unfortunate family circumstances, was living with her father, and her mother hardly ever saw her. And there was a stepmother, who was very kind, but, as is often the case, the girl didn't accept her. And she was leading a rather chaotic life, too. And it took some time before she really... things turned around, and she started realising that it was largely in her hands; that one could only help so far, but that we did depend on her - for her well-being - to come to see us every now and then.

How do you cope - how did you cope - as a GP, with patients who wouldn't do what you told them?

Oh, a lot of patients don't take advice; it's not unusual! And one just has to work along with the patient. I think, anyhow, you can't do much else. You can't impose conditions on people, and you can't regulate their lives, but just try to point out how everything depends on them. What happens to them depends on - to a large extent, anyway - on how they accept advice and help. And, mostly, they eventually seem to come round, but sometimes it's a bit late. With diabetes, particularly, if the control has been wildly chaotic for some time, I think it's fairly - not always the case - but I think the control can help to mitigate the long-term effects, though I think it's not always strictly related to them. Diabetes diagnosis is interesting; the way in which patients present. Not always the classical, you know, thirst, weight loss, et cetera. But I have in mind one quite young, obese woman, with recurrent thrush; recurrent Candida. And she just simply could not get rid of it, and had self-medicated for some time. And then, there we are, lo and behold, we find she's diabetic. And then, the lady with a huge baby - I think a ten pounds, two ounce, or something. A difficult birth. Subsequent blood tests, after delivery, showed that she had a high blood sugar, which hadn't been picked up before. There was, maybe... suddenly occurred. And then a very frightening case of a child with sickness and diarrhoea - how many children have sickness and diarrhoea? - and continuous vomiting. And one just has to have this threshold - low threshold - of suspicion about, this is not necessarily a viral gastroenteritis, it could be something else. And there we are - dipstick test - there we are: diabetic.

- (25) You mentioned the new GPs' contract around 1990. Were there any other changes in the health service that affected GPs?

Oh, huge changes, and constant ones. The ones that I think of particularly were fund-holding, which came in during the 1990s. I don't remember exactly when.

It was a gradual process, actually. Some practices jumped into it, because there were all sorts of inducements. Others waited a while on the threshold, and then eventually took up the initiative. And I think we - our practice - I decided that it was a good idea and that we should enter it quite early, and so, we got organised, and appointed a fund manager. This was something that we weren't going to manage ourselves - we hadn't got the expertise - and this chap, who had a lot of financial and administrative experience, was going to manage the funds for a group of practices. And we... it was an opportunity - which was a very nice thing - for practices to group themselves together. There was a lot of dynamics there, and interchange of ideas, and ways of practising, which was very healthy; it was a good development. And this affected the way in which we related to hospital... to secondary care - GPs being primary care - and the changes in secondary care, the ways in which secondary care was looking after our patients, after we had referred them. And it gave us an enormous amount of control, because we determined where the funds would go, and how we would spend the money, and what we wanted for our patients. Which was influenced, partly, by what our patients wanted from the health service.

- (26) And we did have some very constructive dialogue, with hospital departments, on improving their services, and what part we could play in that. And it was partly a case of voting with our feet, and saying to some hospital departments that we've decided not to have a contract with you for the following reasons. And that made them sit up and dust themselves down, and shake things up, somewhat. And we could then choose the hospitals which we thought gave the best service to our patients, and that included, very much, diabetic care. So, we had a very good relationship, then, established, working hand in hand - not separately as before - with our local hospital departments.

What did that mean, in practice, working hand in hand?

Well, in the case of diabetes, it meant that, rather than referring all patients to the hospital diabetic clinics, which had been overflowing and not coping, we would now use them as a resource, for consultation with difficult cases, and for quick consultation too. So, we had a, pretty well, a hotline to the Diabetic Specialist Nurse, who was attached to the diabetologist. And patients could phone her directly, when they needed advice about how to manage a situation. And this was excellent. And we did it in quite a lot of specialties, but diabetes was one of the most successful. And the diabetologist was setting up a database of the district diabetic register, which was a huge task, but very well worthwhile, because it gave an idea, then, on the demography and the incidence, and different rates of complications, and so on; which has been, obviously, a great research tool.

- (27) And, as a rural dispensing practice, how did your dispensing develop?

Well, doctor dispensing has been an integral part of country life for a very, very long time, in this country. And the benefits to the patients are very obvious,



really, because it's safe, it's instant, there's a direct relationship between the diagnosis of a condition and the provision of treatment for it. And the dispensers, in a practice, also play an important part in the team, because they are aware of what patients... what medication patients are taking; how often they're collecting it; whether they're missing repeating medication; whether they're having some problems with it; and whether they're stocking it up - that's another thing. So, our general principle is twenty eight day prescribing, because we've often found that, especially elderly patients - just out of politeness, perhaps, or habit - had been sending for their repeat prescriptions, and just collecting them in cupboards in their house. We know this for a fact, and the district nurses - often to our, well, chagrin and amusement - bring back big bags full of repeat prescriptions!

Tell me more about the dispensing process.

Well, that's very interesting, and very, obviously, very important, from several points of view. The primary thing about it is the convenience for patients, and the safety of the way in which it's done. And the - as far as the convenience is concerned - we have systems, whereby patients can re-order their repeat prescriptions using a written order. We don't take telephone repeats, nowadays, because they can so often be garbled and twisted in the telephone message. Then the collection of medicines, and provision for remote patients: for a long time, we've had arrangements whereby the medicines can be left at a local store, or village Post Office. But now, those are rapidly receding, and a lot of practices now have delivery services, as well as collection by named representatives of the patients. And then there's the question of safety. Lots of things go into that. The electronic ordering of supplies, and the bar coding checks, electronically, so that mistakes can be identified very early in the process. Double checking, so that every prescription is checked by two people - another person. Supervision by the doctor on the premises, so any queries can rapidly be addressed.

- (28) The training of dispensers is now a very important issue, and we have training courses for dispensers at different levels; as in community pharmacies, indeed. The work is very similar, though there are some differences: particularly the knowledge of patients of a practice. This particularly comes into play when there's someone in having terminal care, and our practice team at the desk - the front line team - know which patients are having a particularly difficult time. And if their representatives, their carers come, they give them very quick service, because the receptionists know, the dispensers know. And if requests are made more often, for example, for a painkiller, the dispenser will be the first person to know about it, and will let the doctor know that the need for analgesia is increasing. And these are important steps in the treatment process, let alone in the dispensing. Then, the looking out for keeping controlled drugs in a safe, locked place; keeping registers of locked drugs. This has all been going on for a long time, in practice dispensaries. The destruction of drugs, according to certain Home Office rules. And so, all these things form part of the business of

general practice dispensing. And the ordering of drugs, so that the stock is not excessive. We have limited space, clearly, in pharmacies, and we keep the minimum level of required stock, but we have daily deliveries. And it's very important that this should continue. There are, I'm afraid, certain threats to the process. And one of them has been changes in the whole business of the wholesale. The wholesalers seem to be having some kind of a war going on - and, of course, the people who are going to lose out in this, inevitably, will be the patients - with supply chains being broken, irregular supplies, and so on. Then there are government changes taking place, which continually review the pharmaceutical supply of medicines, not always taking account of rural practice conditions. And I work with the Dispensing Doctors' Association to safeguard dispensing practice, because we feel it's a very, very important thing, which must continue; mustn't be allowed to disappear. With regard to diabetes, in particular, one of the things that we have to keep a close eye on is the strong pressure - strong government pressure - through PCTs - Primary Care Trusts - to keep down the costs. And there is a great danger that keeping down the cost becomes a priority over the effectiveness of treatment.

- (29) So now, looking back over your whole career in medicine, what reflections do you have about the treatment of diabetes in particular?

Well, a big question! But, I think the first thing that springs to mind is that, whereas we originally were looking at diabetes as primarily a metabolic disease - a deficiency in the production of insulin, and in the metabolism of glucose - now, it's increasingly being seen as a disease of the cardiovascular system. That's one thing. And the other thing is, going along with that, that one sees this, now, in an increasingly ageing population. And there does seem to have been a huge increase in the numbers of diabetics diagnosed. And I think the general view is that it's not just that we are diagnosing them better, but that the incidence is greater, especially in the older age groups. However, looking at the future, it has been encouraging to hear about progress in diabetic care, and there are some very exciting things going on in pancreatic transplants, and the selection of patients for them. If we can muster the resources to do it, probably the outlook for diabetic patients - especially those who are diagnosed at an early age - is better than it used to be, when I first started in medicine. And we hope that with increasing advances in diabetes research, that there will be more ways of treating the illness, and its complications, in the next... the following years.