Interviewee: Helen Zealley
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MM: Dr Helen Zealley has been a Fellow of this College since 1987. In 1988 she was appointed as Chief Administrative Medical Officer of the Lothian Health Board. In 1991 she became the Executive Director of the Lothian Health Board and she was in that appointment until she retired.

MM: Dr Zealley, you were born in 1940?

HZ: [nods in agreement]

MM: So that probably means that your experience and your memories of medicine really are very much of the National Health Service and very little before that, would that be the case?

HZ: I've got a vague recollection of having a jag in 1946, I think it was and… so that must have been some immunisation I was given at the time and I also have a memory, and I know it's 1946 because that was when we moved from Edinburgh to London, of stopping by at Manchester with my grandmother's university friend, and she was a paediatrician and we were going to go and see four tiny babies that had all been born at the same time, obviously quads, and I was heartbroken because I wasn't actually allowed to go in and see them because I was a six year old, children weren't allowed into the maternity units at the time, but my parents went in to see these miracle babies. So that's my first recollection of health services, but certainly the NHS has been most of my life.

MM: But that immediately leads into something of interest, you were born to what was very much a medical family then?

HZ: Yes, yes. Both my parents were doctors, my mother's still alive but she didn't practice after she was married and before that my father's mother was a doctor as well, again she didn't practice after she was married but she was engaged for ten years so that she could practice before she got married.

MM: Then I think that she had experience of, shall we say, state services as well, didn't she have duties in the Poor Law… ?

HZ: Yes, yes. I mean obviously in 1901 when she graduated it wasn't very usual for women to be practicing medicine at all anywhere. There were only six in the class she was in and it wasn't even at the university, they weren't allowed to be at the university it was a sort of separate place and I think,

I presume, that the openings for women at that time were very limited. She did a stint in Dublin, she did a stint in - I think somewhere else in Ireland - and then she came and worked in Craigleith Poor House, which is of course now the Western General and she was there as the doctor, she had a hospital section of 60 beds and she also had to look after the wellbeing of the 200 or so inmates in the Poor Law part of the Western.

MM: Yes I've read about that, that must have been a fairly intimidating experience was it not, not enough to give you another sort of forbidding view of what medical practice was going to be to have your grandmother with an appalling load of clinical…

HZ: Well she never talked about it as an appalling load, I mean I found out subsequently from her when I was older and from what she's written. Interestingly her references for her next job were printed, she had a printed copy of her references and it explained what she had done, the surgeries she had done, the post mortems she had done, the whole shooting match she'd had to do.

MM: So I think inevitably this background, the family background must have impinged on you and to some extent at least determined what you were going to do.

HZ: Interestingly, yes I suspect my grandmother's public health component, because she then went on and in Manchester she worked in a public health… under the Public Health Service as well, I think her interest and commitment to particularly children in deprived circumstances… she used to take me round what were called Toddlers Playgrounds, they're now called Children's Centres, where disadvantaged families' children are looked after and I mean I remember being taken round there from being a tiny tot with her and she was absolutely committed to services, not just health services but support services for disadvantaged children, and that certainly had an influence on me.

MM: And… would [inaudible] was it particularly your grandmother, how about your father? He must presumably… his career must have had some influence?

HZ: Yes I think she probably did influence him as well. He was the youngest son, his older brother had to go into the family law firm so he was actually free to choose and I think he will have been influenced both by his mother and by her brother who was a GP [General Practitioner] in Stockport and again working in a fairly deprived area.

MM: And did you have brothers and sisters?

HZ: Yes, I've got two brothers and a sister and one's a sculptor, one's an accountant and one is… oh she's become an accountant as well.

MM: But your…

HZ: I'm the only doctor.

MM: You have kept the family tradition going on, only you.

HZ: Yes, only me but I've also married a doctor and both my children are doctors.

MM: But then you went to school at St Albans?

HZ: Yes, when we'd moved down… well first off all I was at school in London, the rest of my primary schooling was in London and my secondary school was all in St Albans because we moved out to Hertfordshire.

MM: So you didn't have experience of schooling both in England and Scotland?

HZ: No, no, all my siblings did because they were younger, we moved back when I was 15 and I stayed at school in St Albans to finish off, but the others were all younger so they did their secondary schooling up here.

MM: Did that… was that something that gave you cause to think later of having been at school in England was it of any significance at all?

HZ: Well I regret not being, I regret not being - spending my childhood in Scotland yes, because it makes me not sound Scottish that's a fairly major thing, everybody thinks I'm English and I don't like that.

MM: Tell me, at school, presumably you were already thinking of medicine, even then?

HZ: Yes, yes, I think that the absolute turning point was reading A.J. Cronin's *The Citadel*, I mean that was my absolute…

MM: And what age would you be then do you think, roughly?

HZ: About 12 or 13.

MM: What was the attitude then of your school towards your ideas towards medicine?

HZ: Oh they were very pleased, they…

MM: [inaudible]

HZ: It was a girls' school, all girls. Not all that many of us from the sixth year probably about 10 out of 30 or something would go onto university but they certainly liked people going onto university, there were boards, you know boards with people's names up if they went to university and their degrees. And to go and do medicine, they definitely liked that.

MM: So the input in that sense from your school was entirely positive?

HZ: Encouraging, yes.

MM: Then you decided to go to study medicine at Edinburgh?

HZ: Yes.

MM: Or was that an inevitable choice?

HZ: No, it wasn't, at the time my father was the Dean, so in fact it was actually a relatively uncomfortable choice, but looking back, I mean it seems silly to say this, but because he was employed by university I didn't have to pay any fees and they were paying out three lots of school fees for my siblings at the time and I think the family finances were fairly stretched and I thought it was something I could do to help things.

MM: And what do you think about it now looking back on having spent these years in Edinburgh, were they happy years or difficult?

HZ: Yes, well being the Dean's daughter wasn't the easiest of roles at university. I mean it took a while for me to make my own friends and that was ok, then he became my father rather than me being his daughter, if you understand the sort of subtle change. But no they were good years, I mean university is good isn't it, it's an exciting time, you're learning new things, you're meeting interesting

people. We had some super teachers, I was in the last clinic of Derek Dunlop's clinic in the Royal, Ray Gilchrist, you know some quite big impo… big people were our teachers and that was good.

MM: Were there any who were a particular influence on you? These were very eminent people but how about you personally, did any of them impinge particularly on you and your ideas?

HZ: Derek. Derek in particular.

MM: Sorry?

HZ: Derek in particular, I mean as I say I was in his relatively small clinic in… for my first clinical term and it happened to be his last teaching term so I suppose we knew he would be going and maybe we absorbed it all the more. I do remember Ray Gilchrist, he was terrifying but ok, J. D. Cameron, J. D. S. Cameron, John Bruce, Robert Keller. I mean they were all big names and Edinburgh was a… at one of its peaks, it seems, it has peaks and troughs doesn't it Edinburgh, and it was a good time.

MM: It's interesting you've picked out entirely clinicians. Other people have thought that some of the preclinical ones were…

HZ: [laughs]

MM: These were not particularly important?

HZ: I have to say anatomy wasn't my favourite subject. [Gordon Whitteridge] was pretty scary in physiology. Walter Perry, you know… science, I'm not a brilliant scientist I have to say, maybe the scientific side wasn't what caught me.

MM: And looking back on these long years as a medical student, what do you think now about the balance of the thing because that has changed hasn't it?

HZ: Yes, oh enormously.

MM: Now do you think this shift in the balance has been a positive move then?

HZ: Yes. Yes, I mean I really think five terms laboriously, tediously looking for cutaneous nerves is not a particularly useful education. You grow up, you learn lots of other things during the process but just watching our children at medical school, one of whom was in Edinburgh and one was in Dundee, they had rather different teaching programmes, they both graduated in 91 so that was sort of through the late 80s, so it wasn't quite as it is now but it had certainly changed from our time and the focus on interaction with patients, communication, learning to connect the bits of information, you're sort of getting a whole picture rather than a bit of anatomy, a bit of physiology, a bit of biochemistry, a bit of pharmacology as we had, they've… I think they've ended up better doctors as a result.

MM: And then during that time as a medical student did you already have the career that you eventually came to, did you have that in mind or was it still an open… ?

HZ: Absolutely not.

MM: Right.

HZ: I think… I don't know whether I actually ever explicitly said it but I was quite clear I was not going to do public health because the public health at the time I was a medical student was different than it became. I actually… if I could have absolutely chosen I would have chosen paediatrics or paediatric

psychiatry, you know something with children, but I got married when I was a houseman and it was a transition time for women once they'd had children to work. Most women with preschool children stopped working at that time and the doctors who stopped would tend to go back to do family planning or school doctoring or that sort of thing and I suppose I assumed I might have that sort of career. I wasn't career orientated at all, absolutely not, absolutely not. But I went and did some bacterio… microbiology and particularly virology and got involved with partic… specialising in the virology for the children's hospital so I got my bit of paediatrics there which I enjoyed. And then it became clear that the specialty of virology, I did an MD and I sort of began to get interested and I had two little preschool children by that stage and I was intending to stop but the person who was running the virology lab at the time left, Margaret Moffat, she left and went to Aberdeen and they were actually going to have to close the City Hospital virology lab because she had gone and I was going, so I said that I would stay but I would prefer to be half time and Winnie Thomson who had covered my work while I was on maternity leave said she would come and do the other half so we invented, inadvertently we invented, job sharing for women doctors so it meant the lab stayed open, we were both able to work with our little children and then the lab sort of came back to life again and then Betty Edmond came and after that Alistair McCrae and it sustained and it remains a very good virology lab but we just helped to see it through a two or three year period when it might have disappeared and doing virology at that particular time in the late 60s / early 70s you either became a biochemist, a sort of cellular biology side of viruses or you went up the way and you looked at what viruses did to populations, epidemiology, and I was far more interested in the epidemiology, doing vaccine trials and spread of infection and things like that. So I went for the epidemiology and at the same time a new specialty called Community Medicine was emerging, it was about 1972 I think, 71 / 72. A new speciality of Community Medicine was emerging from the old public health service, the hospital administrative service and the academic epidemiology and social medicine components and it sounded good, it sounded as though… I mean obviously what was being written about it was that it was going to be terribly important in the restructured health service… the 1974 restructured health service and my idea was to continue my interest in infectious disease, particularly in children, in this new capacity as a Community Medicine Specialist. So I then transferred and came through a formal postgraduate training programme for that which involved going back to university to do a Masters in Social Medicine and then doing what was then the new Faculty of Community Medicine exams, did that. And during the training, realised that this new specialty was an amazing one, it was so broad it… against my expectation I found the public, the old style public health, interesting, the historical perspective and then what it was leading onto at that time and administrative medicine in terms of planning services, planning changes to services to meet the new and changing needs of the health service, the health care. It was much more interesting than I expected so I actually didn't go off to do infectious diseases epidemiology, I stayed in the more general mainstream of the new specialty.

MM: But by that time you did have an MD?

HZ: Yes.

MM: What did you… what was your thesis on?

HZ: I did… it was on Q fever, Q fever antibodies in Edinburgh children, which we found as a completely unexpected finding… subsidiary finding of a study of respiratory infections in children and there was something like 20 per cent of the children had antibody to Q fever, for no apparent reason. They hadn't ever been symptomatic and well the sort of long and the short of it was we also tracked that cattle and sheep in the Lothians were infected, they had quite high levels of infection,

and the epidemiology of it was that the children tended to seroconvert at around the age of five, six months and we reckoned… the hypothesis was that they were getting an infection in pasteurised milk so they were sort of semi-immunising themselves but then it went away again [laughs] so it's never been a… there have been sporadic clinical cases or there were being sporadic clinical cases at that time but there was never any epidemic of it.

MM: Were you thinking of… your sort of, if you like, your academic background before going on, you had an MD, after your MD. your membership?

HZ: For here?

MM: Yes.

HZ: [shakes head]

MM: You didn't… ?

HZ: I didn't…

MM: Didn't go back…

HZ: I was scared to do it. My husband had failed it the first time and I thought, "golly, if he failed it I'm bound to fail it" so I didn't do it. Actually I hadn't probably done sufficient postgraduate clinical medicine because I went off after my house jobs and did this virology so I wouldn't really have had sufficient… not that you had to have the time but I probably wouldn't have had sufficient clinical experience at the time. And I wasn't seeking to have a career, the MD emerged because I had this interesting finding that I pursued and so I wrote it up.

MM: But I think you mentioned a master's degree didn't you?

HZ: Yes, I did a Master's that was in Public… well it was called Social Medicine at the time and then I did the Membership of the – what was it called at the time? Faculty of Community Medicine.

MM: Right.

HZ: And subsequently I was honoured to be made a Fellow here.

MM: So… but you had these things behind you before you launched onto the public health?

HZ: Well, yes, I mean the Membership of the Faculty of Community Medicine was the entry qualification… well the legitimacy for becoming appointed as a consultant in that speciality, so that's what I did.

MM: Right, and when you moved from virology then your public health interest as far as I can discover was pretty well directed at children's services.

HZ: Yes, yes in the first… no the very first consultant job I had was Medical Manpower, sort of doing manpower planning for numbers of senior registrars, training programmes for surgeons, training programmes for GPs, introducing junior doctors' hours of work. Some fairly horrendous, if you like, boring administrative things.

MM: And who were you doing that for?

HZ: At Lothian Health Board. Yes but it was very very interesting in a way because I got to know all about every single specialty, the ins and outs, the training programmes for all of them, which

consultants were getting cross with which other consultants, who had sub-specialty interests in what. I learned an enormous amount about health services in Lothian doing that job.

MM: Which must have been useful later?

HZ: Which stood me in very good stead, and I became actually quite a source of knowledge for a lot of people because I just knew that side of what was going on. So in terms of health service planning, which we were doing a lot of at the time, you know there was all the sort of restructuring that has ended up with the shape of services that we've got now with the two big hospitals… well the three hospitals including St Johns, and if you like sadly the loss of all the smaller hospitals, but that was being planned in that period in the 70s. It's taken 20 years to implement it all.

MM: So how long did you spend on… ?

HZ: On that job?

MM: On that part of the… ?

HZ: I was about eight years I think doing that. Yes.

MM: So I had thought you had come back to children's…

HZ: Well maybe it was less than that, maybe it was five years I think, it was 73 to 78 or something and then the consultant who had been overseeing the children's services, Jean [Wilison] who had come from the Public Health, the Edinburgh Public Health Department, she retired so there was a vacancy there and I applied for that and moved into that and I had ten years working with the children's service and that was good, I was… that I suppose was my happiest.

MM: Tell me what do you think was the state of these children's services at that time? Perhaps I should explain why I ask, because there was a comment earlier by the President of this College Charles McNeil…

HZ: Yes.

MM: Because in 1950 he said very damningly that, "Our best men and women will never go into children's services."

HZ: Oh.

MM: He took a very dim view of the state that they were in that time but that… I mean that was in 1950 so one must assume that his ideas were based on what they'd been like by the National Health Service which leads me into asking really what had happened between 1950 and when you went in? Do you think they had become worthwhile?

HZ: Oh yes.

MM: Because he certainly had them written off in his view.

HZ: Oh no, they were very good. I mean I suppose I don't know what they were like in the rest of the country. The hospital service, I mean the hospital paediatric services…

MM: Which is now the welfare services [inaudible]

HZ: Ah well I think I'd need to talk about them as two separate services because they functioned as two separate services. I mean the hospital paediatric service to my mind was excellent. Neonatal

paediatrics was emerging, you know infants were surviving, people were researching and it was getting better because there was a problem initially of child… infants surviving, severely disabled but even that was beginning to improve with the neonatologist beginning to be able to assess which babies were likely to be severely damaged and therefore not striving so hard with those and very very disciplined auditing of both the obstetric and the paediatric components of neonatal services. Within the hospital yourself and Bill up there on the top floor, I mean you were researching the guts and that was knew I remember bringing my baby to you for [laughs] a Crosby Capsule biopsy at one point, Bill working away you know both of you young bringing an academic slant to it, Jim [Farker] downstairs, John Forfar, I'm trying to think, the surgeons were there, Freddy [Robarts], Billy [Bisit] and the plastic people, Mr [Batchelor] so it was… I was impressed by all that. The Community Child Health Service, which was the old Public Health Service, was beginning to be in transition but what it was like when I first became involved was exactly what I had not wanted to be involved with in the Public Health Service. Routine examinations of well children that were sort of purposeless, unconnected to either the General Practice Service or the Paediatric Service just seemed to me ridiculous and some of the people… some of the… I'll say women because they were all women apart from one… some of the women were absolutely excellent clinicians, some of them weren't and it wasn't age related it was whether they actually could understand the whole child. But what we did, and initially, was to develop… and we were very lucky because John Forfar I think was chair of… what was it called at the time? The paediatrics, it wasn't the College… Paediatric Society?

MM: BPA [British Paediatric Association].

HZ: BPA yes. And he was in London and he was wanting to see this cadre of doctors better trained and we also had [Alistair] Donald in primary care who was chairman of the Royal… of the new College of GP's in London and he too wanted to see better training in the community, in the care of children in the community. So we had a fantastic opportunity in Edinburgh to develop training in this, what is now known as community paediatrics, it was been called community paediatrics and Jim [Farker] and John Forfar set up the School of Community Paediatrics which I was involved in helping to ensure that that happened, develop training programmes, [Alistair] got a special programme for GPs to come and do six months, to sort of have a cadre of GPs who'd had extra training then we were able to introduce a sort of… I don't think it was called senior registrar… and senior registrar training. We had to use the old community child health terminology initially but we managed to change it and Edinburgh, Edinburgh really led the way in developing training in community paediatrics and we were lucky we had some one, two, three… three or four extremely able… they were again women, women doctors who, because women doctors were now beginning to work, they were beginning to work right through having small children, there were beginning to be arrangements to work part time, there were beginning to be arrangements to have your children looked after, so it was beginning to be possible for the bright young women to stay in clinical medicine and my experience from having done Medical Manpower, because we actually officially launched, in Lothian Health Board, a job share scheme, but my experience of that and knowledge of how training programmes worked made it possible for me to sort of help find practical ways in which these bright young women could fulfil the proper and rigorous training requirements of the College, the Physicians College, at the time and get a proper training in community paediatrics so they would be respected by… and be properly eligible for consultant posts and respected by the hospital colleagues. It wasn't always comfortable but I think most of them have proved that….

MM: In what way not comfortable?

HZ: Well there were bumpy times, there were bumpy times when the GPs still couldn't see that this you know, another doctor seeing their children in a community setting being acceptable and some of the hospital paediatricians I think found some of the community paediatricians… they needed to prove themselves and I like to think that they have proved themselves.

MM: [inaudible] from the point of view of the service developing, what was being provided, developing at that time. I'm quite interested in the view of the, the public view of these services, one of the reasons being that it's reading about things in the past that go back far enough to John [Bale] and people like that, they set up their ideas, they were at that time very ambitious and [inaudible] but it pretty well came to nothing and if not nothing less than it should have been because of resistance from the families themselves, that for example the original scheme for examining these children had to be cut down because families said this was an invasion of privacy and so on and there was resistance again to immunisations in the 30s and 20s. Do you think that had changed? I mean what… when you were organising these services you can quite see that that was an ambitious and very successful arrangement from that side of it, but how about the patients' side of it and the acceptance and the readiness of the public for that?

HZ: Well a couple of things, I think it had changed enormously and I suspect it was because by the… we're now into the 1980s the public had had a National Health Service for 30 / 40 years and expected to have a breadth of service. When I was doing the rubella vaccine trials, you know obviously I was looking at responses, public responses, to a vaccine programme in much more detail and I think we had two percent / three per cent refusals it was tiny, absolutely miniscule. We were blood testing all the girls first and only immunising those who were found to be seronegative but it was literally two or three percent who refused the blood test to see whether their children needed it and then nobody refused it if they were found to need it because you know the logic was you know, your daughter was at risk, except for one school, the Rudolf Steiner school has a... you know the school doesn't approve of vaccination in general so the children there were given their results and it was left to the parents to decide whether they would or wouldn't go to their own doctor but that was a handful of children out of the whole cohort of children in Edinburgh.

MM: So was this sort of resistance to immunisation we hear about now do you think this is a regression for some reason?

HZ: Yes because the… I mean at the time I came into this thing called community medicine in the early 70s that was the pertussis, the drop off in the pertussis immunisation stimulated by Gordon Stewart, now that happened… it fell from something like 80 percent wasn't it? It was well over 80 and then it dropped down to about 30 or 40. And I think that the drop off was not only the adverse publicity but that the public health service at that time was in chaos because of the reorganisation in 1974. There was nobody there to stand up and persuade people that it was ok or that not being given pertussis ran the risk of whooping cough which we saw come back later on. So by the 1980s something else had changed, by and large children were being immunised by their GPs, so they were getting a primary care service from their GPs, children. So the old child welfare service, the child welfare clinics were less, they weren't doing… not as many children were attending because the GPs were doing the vaccine bit. Child pre-school surveillance was not as structured and evidence based as it now is, so it wasn't pushed and it wasn't monitored and so I don't think we even knew how many children were being covered and the school health services, as I say, continued to see all children and not a selective group of the children who needed it. So that was all part of what we changed as well, saying that a child who has had routine surveillance in an evidence-based programme from its GP, there is absolutely no need for that child to be given another full medical

when they come to school so long as there is a sharing of records and sharing of information, so the school health service can concentrate on providing what is effectively an occupational health service for children with special needs, it can be the service that acts as the paediatric service in the community for children with long-term disabilities of various sorts or children with very difficult behaviour problems or children with profound and complex social needs.

MM: With it that has a slight disadvantage, doesn't it, because a school population is a very nice documented solid population for any kind of review or studies…

HZ: Very tidy.

MM: You've got them all on tap, they're there.

HZ: You can still do that, there are still research projects that catch all children and a lot of vaccines, new vaccines are almost all introduced through the school system because it's the most efficient way of getting a new vaccine into a large number of children.

MM: But is there somebody now looking and saying what the instances of dental caring is?

HZ: Yes. Oh yes the dentists are still doing that and the nurses are still weighing and measuring them so that those anthropomorphic data is still…

MM: Because that was one of the things that was abandoned in the 20s and 30s so that was new to get that back in.

HZ: Right.

MM: So what you're suggesting is, saying not suggesting, is that there was a co-operation between the GPs in some matters relating [then], did that work smoothly?

HZ: No.

MM: GPs…

HZ: No [laughs]

MM: [laughs] That was an invitation to tell us about it.

HZ: The GPs, my daughter is now a GP and I'm beginning to be more understanding of general practitioners. They just are hugely diverse in how they operate, some are extremely good at working in partnership with, whether it's hospital consultants and giving good information across, similarly with the community paediatricians, working in partnership and "I'll do this bit, can you do that bit?" and particularly for children, for families where there is a child or children with special problems, others are still… no I don't think they are still writing "Please see…" you know I think general practice has improved over the last 30 years. I think that they are mostly better able to work with others but it was bumpy to start with, and certainly, there were in the 80s GPs who on no account were going to pass any clinical information to one of these school doctors and just to go back to your question about what did families think, I found that families were absolutely shocked to learn that the school doctor didn't know this bit of information about their child in the health service because they thought the health service was all one service. So it was really the reverse of what the GPs were anticipating, that by and large the parents expected information to be shared.

MM: This was something I found very difficult, that patients would talk about you, me in a collective sense. That I wasn't me, I was a collective thing and that embraced every part of the health service.

HZ: You are, yes, yes.

MM: And that embraced every part of the health service, which was very much a patient attitude to things. But then you think that these services, you know, were valued then by the patients by and large?

HZ: Yes. Yes, in fact when we – as we were changing the school health service, which was partly because it needed to change but it was also partly because we were going through major financial problems at the time and having to reduce and reduce the numbers of doctors around, so for all sorts of reasons the poor community child health service was seen as a soft target by both the hospital doctors and the GPs, but as it turned out, it probably wasn't a disaster that that happened because it actually became more of a stimulus to change.

MM: Could you say… explain a little bit about that financial pressure, I mean when was this?

HZ: Well the… until about 1984 or so, 83 / 84, all the time I had been working in this administrative side of the health service we had had our allocation for Lothian each year plus two percent or plus two and a half percent or something so there was always a real… that was over and above inflation increase in the allocation until about 1983 or four. And in 19… initially it just stopped, there was no increase, we got inflation correction but we didn't get any extra and then year after year we started getting what was called "negative growth", we started getting cuts. They had all sorts of fancy names but the commonest one that settled down was called "cash releasing cost improvements" which meant that you had to change things and release cash in the process. I mean the government's still doing it in terms of calling it modernising and things, they use these words. So what happened from about 1984 is first no growth for a year or two years…

[Interruption on tape – "One, two, one, one."]

HZ: and then actual cuts in the allocation and initially it was possible to squeeze efficiency savings out but there came a point where it had been squeezed and squeezed and squeezed so that by… well this efficiency saving, the child health doctors were seen as a fairly soft one for doing some cash releasing cost improvements, they were an early one, but after I had left my specific involvement with the children's service I had then become what is called CAMO, Chief Administrative Medical Officer, later Director of Public Health, the year-on-year savings were beginning to really be almost impossible to find without impacting on the service and in 1990 / 1991 what happened in Lothian Health Board was that it collectively, all the hospitals collectively, were grossly overspent, and not only overspent but nobody quite knew how overspent so the whole system was in a bit of chaos and we had to do some fairly radical changes at that time which were fairly uncomfortable. I mean there was a big package of hospital and ward closures, I had to save a million pounds out of the medical staff budget, which is a lot of posts, that was in 1990. And so the transition of the community child health service contributed again to more savings to that, and so that was why we ended up with a different type of service afterwards.

MM: To bring back, I mean rather [inaudible] material losses from the service do you think due to that squeeze?

HZ: It was an incredibly uncomfortable time for everyone, anger, service changes that weren't under… you know were difficult to understand. In practice, some of them in retrospect may have turned out to be for the best, there were changes that were going to have to happen anyway. I mean an example I suppose was the closure of the paediatric unit at the Western. I was particularly sad about that because I had done paediatrics down at the Western, but there were so relatively few

children coming into hospital at that time. We had over provision of hospital beds, the staff at the unit in the Western were really not getting as much experience as they needed to be maintaining it as an acute paediatrics service so it was probably the right thing that it closed and it almost certainly would have closed at some point anyway for clinical reasons and this discipline of having to make service changes just may have brought it forward. What was fascinating and we were incredibly lucky, although this 12 or 13 million, I can't remember what it was exactly, total saving had to be achieved, the Area Medical Committee instead of what it might have done and what I'm sure it would have done in many other places, saying "a plague on you" to the administration, "what a cock up you've made of this whole thing, you know, how dare you, you need to go", you know a very angry response, there was an angry response but the Area Medical Committee said "well if 13 million pounds worth of cost in this health service has to come out, we are going to take a very active part in determining what that should be, so that it is not just the easy, soft targets that the administrators think that they can take out but it should be done on the most appropriate clinical grounds", and the clinicians were fantastically helpful in terms of identifying such things as maybe the time's come for the paediatrics at the Western and obstetrics at the Western to close.

MM: I think, could we stop for a break?

HZ: Yes, yes.

[Break in interview]

MM: Before we move onto talking about your most senior posts later on, could we just at this point say something about how you had managed personally with family, children growing up, looking back over that whole period. I mean, difficult?

HZ: Very.

MM: Less difficult? Memories of it?

HZ: Right, it was difficult, it was hard work. We were incredibly lucky because the university had a nursery which it had established I think just shortly before our two were at the stage of needing to go to a nursery and it took babies from six weeks, so we used that for the preschool period and it ran all through the year, it only had Christmas holidays and I think it started about half past eight in the morning and went through until six. So it was an amazing service and I couldn't have done what I did without it. There are now, 2004, lots of such nurseries, but it was the only one of its kind at the time. Now I say we used it for both of them, our second child started at six weeks but it hadn't been there for our first child. What I did with him when I first went back to work, I took him with me, I took him to the lab, I kept a pram there on the balcony of the virus lab and he spent most of his day asleep, but I was still feeding him. So I fed him, there was a big sort of anteroom to the ladies toilet where people changed and we used to go in there and I fed him and looked after him when he got back in his pram and I worked away. And two stories from that, one was that I thought that only the people in the lab knew but one day there was a visitation from the hospital board of management and I thought "Oh goodness me, oh dear, what are we going to do?" and what I heard was Mr [Wellstead], the board secretary as he opened the laboratory door, the big swing doors, said to all these ladies and gentlemen from the board of management, "Ah we must all go and see Dr Zealley's baby", so they had obviously known all along but I hadn't asked and therefore they hadn't had to say no, they just acknowledged it, but he was by that stage about six months and I was at the stage of looking for a baby minder to look after him, which we found just near to the City Hospital which is where the lab was and so he went to a marvellous baby minder lady who had been a washer up in the lab, she was

just a wonderful, wonderful… you know one of these born mothers, grannies who – her house was always full of children and he was spoilt rotten. So he was there until the other one was born and then they both of them went to the university nursery. So that was preschool and then that all worked because it was continuous throughout the year and things and then children go to school and you actually find out that children of school age are much more difficult to make arrangements for because they go to school in the morning, they don't go to school in the afternoon, you have to have arrangements for the afternoon, you have to have arrangements for the holidays, you have to have emergency arrangements for when they're off school if they're unwell. So that became more difficult but in fact Aunty Molly, who was this baby minder, came and looked after them at our house and that all worked well, and then she grew older and wasn't able but by that stage they were getting older so I had somebody who came to the house for the time when they came home from school and that all worked out. But ironically [Iain], when he went to university, one of his buddies at university turned out to have a father who had worked in the virus lab at the same time as when he had been there as a baby so [Iain] constantly rags me about how I brought him up in an incubator and how dare I and I risked his life and all of these things but that sort of is a story from the time he was there in the lab. But it wasn't easy, it still isn't easy for families, this very week I'm looking after my younger granddaughter, whose mum is a part time GP and her dad's working in hospital medicine, because she's got chicken pox and the baby minder that she goes to looks after a little boy who's on treatment for leukaemia so she can't go to the usual baby minder, which is fine and it's lovely for us and we're glad to do it, but that happens and it falls to the parents but it still tends to fall to the mother parent rather than the father parent to have to pull out stops and to do something different.

MM: And the fact that your husband was in medicine too might have helped too?

HZ: It helps. Yes, he was helpful, I mean I just had and unbelievably demanding job. Although it wasn't clinical, the hours were unreal, the demands on it were unreal and Kirsty, she went through the same school from P1 to S2, or second year sixth form, and at the end of her whole career she got a special sheet saying she had had no days sickness in her whole school career, because she wasn't allowed to be sick. [laughs] I mean we were lucky they were actually both pretty well, pretty fit children, but she wouldn't have been allowed to be sick.

MM: So what stage were they at when you became a CAMO, roughly?

HZ: 1988…

MM: So they were independent by then?

HZ: Yes… golly don't I get disorientated. Yes, they were at university, they were sort of both halfway through university.

MM: Could you tell me about your move into being CAMO, I mean how did that appointment come about?

HZ: Ah, well it came about sooner than it might have done because my predecessor Colin [Bruff] found that he just couldn't tolerate the change to the management arrangements that happened in 1986, which was when general management and general managers were introduced to the health service in Scotland and previously the senior management arrangement for a health board, replicated at different levels in the service, was for a team leadership of a doctor, a nurse, an administrator and a finance officer. They were called the executive team I think it was called and what tended to happen was one of those four people tended to take a leadership role and when

that happened and the other three were comfortable with it there was some quite good, there was some quite effective, management. But what happened more often – this was around the UK – what happened more often was that one would tend to take a leadership role and the others resented it and there was conflict within a management team so that particular management structure that was introduced in 1974 wasn't the world's most effective one and Mrs Thatcher, who was Prime Minister at the time, asked Roy Griffiths of Sainsbury's to look at the health service and make recommendations and he – for the management of it – and he recommended, and I put it in quotes, "the introduction of general management" close quotes, and talking to him on a one-to-one basis afterwards what he meant was just clarify which of these people is the lead manager so that it's quite clear but in practice what happened was a whole new cadre of people called general managers were imposed on the service, or introduced to the service, and by and large they tended to be the administrator who applied for these – the administrators applied for these posts – so there was a feeling that the administrators have won in a battle, mostly with the doctors and occasionally with the finance directors, finance officers. Anyway what happened in Lothian was that a guy… the person who had been the secretary, the administrator of Lothian Health Board reached retirement age and he opted out and within Lothian a general manager came up from the south, threw his weight around a bit, and my predecessor who had been CAMO, he'd been, I don't know about six years at the time, it was a very… it was uncomfortable for him to have this guy come in and rule the roost where previously as the Chief Administrative Medical Officer within Lothian he had tended to fulfil the leadership role, lead the planning function, and he stuck it out for two years with this general manager and couldn't go on, just didn't want to go on and he had reach a stage where he was able to take earlier retirement and go so the post came up. I didn't like the general management, I didn't like this, to my mind, demoting of medicine but I recognised that it was what it was, you know, it was what was happening and the thing was to get stuck in there and try and make the best of it. So I was prepared to go along with it and applied and it wasn't entirely comfortable, it was supremely irritating at times to have people whose knowledge base of the frontline of the service, the real challenges of the service was theoretical rather than a real practical understanding but one of my functions was to try to educate them, to try to help them to see why some particular proposals would just not work and how best to implement other ones that would work but needed to be introduced in an appropriate way. So instead of doing what I really would have preferred to spend most of my time in that job doing, namely working on the preventive side and helping to improve health and preventive medicine, I found myself doing much more of sort of firefighting ensuring that worse things didn't happen and it was actually during this particular general manager's time that the big financial problems happened because he couldn't do it, he was out of his depth, he didn't… he just lost the plot and didn't know what was happening. So he actually eventually went and the chairman who hadn't identified that the general manager couldn't do it. So then we had another one, new chairman and a new general manager and after about four pretty uncomfortable years it became clear that that general manager couldn't manage either and he went. The chairman stayed on with that he was able enough but… he was ok, he was maybe more… he came from industry he was maybe better able than I was to see that actually some changes were needed but it wasn't the worlds… it wasn't a comfortable ten years or so and we kept having restructurings, reorganisations, enormous amount of energy, time spent on keeping reorganising the service as though it's organisational structure was what was important, whereas in fact what was important was ensuring that it worked as a coherent whole and that the interaction between the front line and patients was ideal.

MM: Was the major pressure point finance at that time or was it policy?

HZ: Finance I think, because we were still having these year-on-year cash releasing cost improvements. The tightness of finance made it really very difficult, yeah.

MM: It's probably a difficult question because this was a particularly difficult time but can you say a little about what being a CAMO was?

HZ: Oh right. Well the title – isn't it awful? Chief Administrative Medical Officer. It emerged from the former Regional Hospital Board Senior Administrative Medical Officers, that was pre-1974, and then they had Principal Medical Officers and Senior Medical Officers so this terminology Medical Officer was very… they were clumsy. People who had been in Administrative Medicine for a long time were very comfortable with it. I found it uncomfortable and I think they just used the word chief instead of senior to indicate a change. What was… it was always a slightly ambiguous role because I was the Chief Medical Advisor to the Health Board, to the Board. I didn't have a formal relationship to the clinicians, either the general practitioners who, of course, are independent contractors or to the hospital consultants, but I was responsible if hospital consultants needed disciplining, that was my function, to do any disciplining or investigation and things like that. So in theory it was a hierarchical role vis-à-vis consultants but it wasn't actual, I mean I couldn't go round it would appear… I would have had my legs chopped off if I'd gone around telling consultants that I was their boss and what they were to do and I certainly never worked like that. I hope nobody ever thought I worked like that but by the same token because of this formal disciplinary role on behalf of the board, certainly my husband used to joke that I was his boss, which wasn't the case but what we did do and what I think we did very successfully in Lothian was encourage groups of consultants to work together in Divisions, do you remember Divisions in hospital management committees? And function with elected… usually elected leaders from amongst their own group of paediatrics of medicine, of surgery, of obstetrics, or whatever and I like to think that in Lothian that both my predecessors [Ian] Campbell and then Colin [Bruff] and myself all sustained and helped that to happen. It didn't happen everywhere, there were not as effective – the clinicians didn't work effectively together in all of the Health Board areas and I think that is something that we did try to achieve and I certainly saw that as a function of my way of fulfilling my role as Chief Medical Advisor was to support and encourage the clinicians to develop advice, strong clinical advice, and then take that and support it into the Board.

MM: And did a CAMO at that time influence policy?

HZ: Oh yes, yes. I was talking about the recovery package for the savings and the recovery package was almost entirely my recommendation, but my recommendation was that which had been built up collectively through the area medical committee. I mean obviously I worked with the various divisions and groups that were putting forward proposals, (A) to ensure that they understood that if they couldn't come up with effective proposals somebody else would and they might be much less effective so it's a bit of a reality check but also providing information and analyses of throughputs workloads and things like that, our team produced that so that the clinicians had the data with which to bring forward reasonable recommendations.

MM: One of the things that interests me in that is, in regard to policy, and did one reaching the board evolve its own sort of list of priorities, for example, which might not have been shared by others, because if you've got pressure and having to make choices then clearly somewhere in your mind you would have to have your own priorities as to which services were more vital than others?

HZ: Yes we did and implementing some of those policy changes were not always easy. A good example was the introduction of geriatric medicine, whose resources came almost entirely from the general medicine world, both in terms of clinician appointments, that it would be not taken for

granted that physician X coming to retirement would be replaced by a physician but might be replaced by a geriatrician and the physicians fought quite hard against that, particularly the physicians in the Royal.

MM: Was there not a phase at least where there was tuberculosis and from that point [inaudible]… ?

HZ: Yes that was just about passed before I came in. But yes you're right the initial geriatric physicians came from a tuberculosis background both literally in terms of they had been – [Iain Milne], Jimmy Williamson – had been chest physicians, tuberculosis physicians, and as the number of tuberculosis patients diminished they saw a new world.

MM: Because very often the [accommodation] came from the same source.

HZ: It did indeed, it did indeed. But by the time I came in the development of geriatric medicine was continuing and they'd run out of that resource and it was coming out of general physician, mainly because it was, you know, general medicine wards were full of very elderly people with multiple needs that the specialist… because there was of course the same time of growing specialities within medicine, that the specialty physicians weren't necessarily best able to look after elderly people with multiple pathology whereas the geriatricians were. So it was, on the one hand I think general physicians or the specialist physicians, were glad to have these older complex patients removed, but they didn't actually want the facilities removed as well. But that probably is one of the – a very big change that happened. The complete restructuring of the hospital service in Edinburgh happened during my period of… I think I counted up we closed 17 hospitals in the period that I was both a consultant and CAMO, which is a lot of hospitals. Built the new ones, the new St Johns, the new Royal and major, well effectively rebuilding of, the Western and that, the planning for that, started in the late 60s, for that whole restructuring of hospital provision in Edinburgh. So yes, the medical side was very very much involved. In terms of another service which I saw during my period was the introduction of a complete new service for HIV. New disease, major problem in Edinburgh, rather than Lothian overall, but major problem in Edinburgh, needing… impacting right across the board, so that had to be introduced as well.

MM: I'm curious about the matter of priorities. Could you identify and say, you know, in the Lothians these are our priorities and we can detect a difference let's say from another region in any way or was there a pressure on a certain degree of conformity in the regions from above?

HZ: Initially when I first came in in about 1974, it was clear that Lothian was well ahead. Geriatrics at that time was the priority to be developed, later on it became… we were given priorities from the Scottish Office. Now I don't know whether we were given geriatrics as a speciality as a priority from the Scottish Office, I suspect probably we were, but it was being developed more actively in Lothian than in other places, I think that certainly was the case. Mental health was the, well the SHAPE [Strategic Health Asset Planning and Evaluation] priorities, mental health and geriatrics were definitely given as a national priority.

MM: A sort of particular interest of mine that your priorities, they were coming from the Scottish Office, was there any… do you think that they in turn were given priorities by way of Westminster or did they… ?

HZ: National priorities? They certainly had autonomy, the Scottish Office has always had a degree of autonomy from the English Secretary of State for Health. I suspect – I don't know this but I suspect that similar priorities will have been identified in England because there were similar needs, growing older population, paediatrics wasn't a speciality because the number of children was going down

and the resource available within paediatrics per child was effectively increasing but within a fixed envelope, apart from this bit in the community child health services that I talked about earlier.

MM: It's just in the past the Scottish Office was able to have quite big differences, for example difference in policy in the old days with the emergency medical service and what they're doing with the Clyde valley experiment and all these things which were entirely Scottish initiatives I was just, since I've been interested in this in the past, I wondered to what sort of extent that kind of autonomy persisted, because the pressure from the Treasury of course must have ensured a degree of conformity.

HZ: Yes, but no, there were organisational differences. Very interesting – I can't remember exactly when, but in 1974 the whole UK was sort of given a fairly similar structure, that it was a big reorganisation of pulling the hospital administration and the public health and the GPs all in and it was UK-wide and both north and south of the border there were both area Health Boards and Districts there was a sub… Area Health Boards were strategic, Districts were operational that was the arrangement and both north and south of the border continued like that until, I think it was about 1982 or something, and that was the first of the reorganisations, that it was clear that it wasn't working quite right and the real reason that it wasn't working quite right is that actually within health care you can't entirely separate strategic and operational. The strategists have to really understand operational matters and the operational people have to feed into strategic change. But managers don't understand that, they think in management theory and you have strategy and you have operational. Anyway there was to be a change but interestingly in Scotland we disbanded Districts, in England they disbanded Area so there was a separation of the ways at that time and so England sort of had far more Health Authorities, as they started calling them then instead of Health Boards, because they'd taken all their Districts to become autonomous Health Authorities whereas we stuck with the bigger strategic group and it's fascinating for me to see this current restructuring north and south of the border which is hugely different, the Scottish NHS calling itself the NHS in Scotland, no NHS Scotland, a logo for NHS Scotland, every health board has to use the same logo, in management speak it's called branding, but each… they all use NHS in the same font and it's NHS Lothian, NHS Glasgow, NHS Fife and the overarching one is NHS Scotland. So very clear signal that the NHS is one family, that it works as a cohesive whole, whereas in England they've gone down to things called Primary Care Trusts, so the general practice bit is hived off, hospitals are going off autonomously, sort of almost pre-NHS, not just pre-1974 but pre-NHS, going off autonomously and raising their own capital in the market place and things like that.

MM: And that of course has got its origins in history hasn't it? I mean the Scottish system has always been centred on the university.

HZ: And a coherent whole, yes.

MM: Since the university set up was the core of the thing, everything followed, which certainly wasn't the case in England.

HZ: And I anticipate that in Scotland we may go back to rather bigger strategic groups, possibly to the five that we had in 1974 when I came in, the regions. There's certainly lots of encouragement from the centre for Health Boards in South East Scotland to work together, the Health Boards in the West of Scotland to work together, you're absolutely right, around the university catchment zones.

MM: And you became the executive director… ?

HZ: Yes.

MM: If we talk about that – is that essentially the same thing as the CAMO or was there a material difference, distinct from the title of course?

HZ: It was one of the reorganisations. Through the 1980s and continuing there seems to have been reorganisations of – restructurings, reorganisations of the management structure about every two years, and one of them, and I can't remember exactly when but probably about 1996 or so, one of them introduced the concept that the lead officers of the Health Board, the doctor and the – no the lead officers within the Health Board would be appointed as executive directors alongside non-executive directors like business, like the commercial world, whereas previously we had been staff and the Health Board members had been members and we were different, we were their employees. Now that particular reorganisation made it that the general manager changed his terminology and became called a chief executive and he was ex-officio going to be a director and there could be three other directors and it varied from board to board which three of the senior staff were appointed, mostly the CAMO was appointed but not always and the difference was that as well as being appointed to my job I then got appointed as a director by the Secretary of State so I sort of had a double role and there were moments where I smiled to myself and thought golly if I really get very, very distressed, and I almost did in relation to the introduction of Trusts about what's happening, I can resign from being an executive director but I can still stay in my job as CAMO.

MM: So it wasn't in fact simply a title change?

HZ: It wasn't no it actually and in one or two places the CAMO was not appointed as an executive director because the chief executive had it in for them. Quite uncomfortable when that happened.

MM: What happened to chief nursing officers and all of the rest, did they…

HZ: Chief nursing officers disappeared, the chief area nursing officers disappeared in… it's terrible I can't actually remember which of the organisation…

MM: Why was that?

HZ: They mostly hadn't made a major contribution in the strategic role. Very, very important in the subsidiary management you know where it was managing large groups of nursing staff, developing nursing staff, but they hadn't mostly played a big role at a national level – at a board level.

MM: [inaudible]

HZ: I think it was just reflecting reality to be honest.

MM: A pragmatic decision rather than...

HZ: Yes…

MM: … a theoretical one.

HZ: Yes. But every board now has to have a nursing officer. I don't know whether they are necessarily executive directors but they do necessarily have to have a nursing officer. Oh, they have to have a director of nursing, all health boards, it's a given.

MM: Right, so how long did you… were you executive director then?

HZ: Well I stayed as CAMO because CAMO is the terminology that's in the legislation for certain things to do with the public's health. We reintroduced the terminology Director of Public Health because our specialty decided, quite wisely I think, to change its name from Community Medicine,

which nobody understood, to Public Health again and we started calling ourselves Directors of Public Health and that's now become an accepted terminology. So CAMO remained for the legislative role but I gradually stopped using it, Director of Public Health, because that more clearly described what I was doing, what I was aiming to do, improve the public's health and Executive Director, I was an Executive Director of Public Health, if you like, and I was that, I think it was about four years, I retired in 2000 and I can't remember when… I think it was 1996 or something the director role came in.

MM: And this move back to recognising it as public health, do you think is a good move?

HZ: Yes I do. I think… public health in the 60s and early 70s was not very impressive but before that I think it had a very proud history. I think the history of public health from about 1870 or so, right through, I think actually is very impressive when you think of the number of other disciplines that have emerged out of public health, health visitors, the veterinary services, the environmental health officers, the sanitary inspectors, social work emerged out of public health, health promotion. Now, I mean they are all independent disciplines now and collectively the public's health requires all of them and many others to work together. But we now are sort of clear that we have three functions, we have… as public health doctors, we have health protection, which is a very traditional protecting of the public, which of course now goes into chemical hazards, nuclear waste all sorts of things like that. Health improvement, which is about helping individuals to understand what makes them ill and how they can stay healthy but also back again working with local authorities, other organisations, to say that you know what you do as a council actually impacts on the housing people live in, all the environmental structure within which people live, so that's a health improvement. And thirdly planning and contributing to the planning and evolution of health care services so that they are appropriate to meet the needs of the pathology that's around at the time.

MM: In this public health scheme, I can have no doubts about the value in how it would work when you're working through institutions. What I'm interested in is working directly with the public because that seems to me to be a very problematic area over the years, you know what they are calling it the health education.

HZ: Well we… yes in terms of one-to-one work with the public, as doctors our main function is with, is in relation to control of communicable infections, I mean meningitis cases, it's our job to go in quickly and cope, not with the clinical case but with the contacts and things like that and that remains and case finding and tracking and finding and helping the environmental health people to find the root cause of [legionella], salmonella, e. coli, whatever it is. So that's our immediate public health interface with the public. In terms of health behaviour, I suppose the public health doctor's role tends to be primarily epidemiological identification of what processes are happening, working with epidemiologists on, say, diet and then working – absolutely, you're right – through organisations to try to influence the food that's available to people and try to ensure that people understand, whether through one-to-one education which would normally be through their GP or through their practice nurse or in that sort of setting. I mean smoke stop clinics, for instance, are run in general practices mostly and our job is to help ensure that those smoke stop clinics can happen, okay to encourage primary care to offer them, to ensure that the funding's there to do it. So you're absolutely right the function is, and its explicit, public health functions through the organised efforts of society, using whatever structure happens to be the prevailing structure – organisational structure of the time.

MM: I watch all these [the comments] on television about smoking and one thing or another and hark back to [inaudible] 1930s and one of the things which they were very firm on were such campaigns were a waste of time.

HZ: Well they worked with the wrong people, that's the trouble. No, they do work, they track them and they work. I don't know if you're spotting, but at the moment the smoking campaigns are trying to raise awareness of the issue of passive smoking because the evidence that's beginning to emerge is that passive smoking is actually much more of a problem than we realise, it's not the relatively small number of lung cancer cases, it's actually the impact on cardiovascular disease and places that have managed to achieve bans on smoking in public places they've seen a step change in coronary deaths within a year or two, it's that quick and so what's happening at the minute is quite a number of initiatives to try to raise public awareness of the danger of public smoking – of passive smoking.

MM: In the last few minutes I want to hark back to – I hesitate to call it the feminist angle but…

HZ: It's alright [laughs]

MM: This is one of the tremendous changes that has taken place over your years in the profession because women are no longer exceptional presence they are beginning…

HZ: To dominate [laughs]

MM: To dominate and that leads into other problems as I see it of staffing in the health service in the future. I mean one hears of people sort of moving to the south and to private practice sort of moving overseas in academic posts and so on. Do you take this kind of gloomy view of the future of the staffing of the service in Scotland particularly?

HZ: I'm not gloomy, I'm delighted to see that it is… that women no longer have to make a choice, that they can choose and that the structure even sort of bends over in their favour in terms of when they're in training, moving from place A to place B if her husband's job changes you know even that is beginning to be overcome. Sometimes I think slightly unfairly to the men and I say that because my son-in-law is having to travel every day to Dundee because that was the only place where a specialty registrar post came up in his specialty and Kirsty, his wife, is a GP here so he's got this long journey and apparently it's because all the specialty registrar posts in Edinburgh keep being taken up by girls whose husbands have come to work in the banks and things like that in Edinburgh so I think there has to be a caution and a fairness, not necessarily equity but a fairness. But recognising that the women will probably want to work less than whole time for a period, but not forever, it's six years, ten years possibly but they'll still have 20 or 30 years when they'll be back and comfortable working full-time, given that the whole medical workforce is not being expected to work such long hours in the future, you know, rightly or wrongly whatever one thinks about it the consultants of today and tomorrow expect a different life than the consultants of yesterday in terms of the amount of time they are going to be giving to their profession, whether they are men or women and that's an inevitable consequence of the introduction of a concept of working hours which came 20 years ago to junior doctors and it's just working its way through the system as well as obviously the European directive on working hours which is there as well.

MM: The last thing I was going to bring up, to what extent are we going to be drawn into European practices and standards and the European registrar, specialists and so on.

HZ: Well we've got a register now, we're still managing to maintain a rather longer and more disciplined training to get on the register. I don't know, I think we might move to a European one,

but I don't think it'll matter. I think what we're doing nowadays is training… we're still recruiting the most able young people, girls and boys. They are amazing these bright young people and they are being trained at university now to go on learning forever, so that it won't just be the four years of their formal training programme that is their training, they'll be training in an ongoing way and in fact remaining on the register requires that they go on training, so I don't worry about that too much and actually the working out of the women's part-timeness is alright, what is showing up is of course is that the UK has fewer doctors overall than most other countries and that is beginning to be addressed as well. So I would be optimistic.

MM: That sounds like a very good optimistic note on which to end.