

# ABCD

# Newsletter

The Official Bulletin of the Association of British Clinical Diabetologists

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## EDITORIAL

# Why another Newsletter?

## Peter Daggett Editor, ABCD Newsletter

Why do we need another newsletter? The simple answer is to let our members know what is going on and to give them a chance to say what they think about the Association. It is important to communicate and I hope that the *ABCD Newsletter* will become a dialogue. We intend to lead opinion in the management of diabetes, but cannot do this without the involvement of all hospital specialists. Our position is being eroded from without and within the profession. The Department of Health is persuaded that diabetes can be looked after more cheaply in general practice, even when there is no evidence for that belief and in fact some against. General Practitioners themselves have decided that diabetes is indeed something which they (or more likely their nurses) can deal with. Often it is, but it is clear that many GPs are following a 'cook-book' and as a result some patients are not receiving the best advice.

We value the help of our colleagues in general practice in dealing with the increasing

numbers of people with diabetes but we must convince all concerned that we need more specialists in this field. Diabetologists are good at communicating, because we spend much of our time talking to people. We should use this ability to encourage patients to persuade managers and politicians about the importance of diabetes and the need for hospital-based specialists. In the past, many of us have felt like lone voices when faced with the massed ranks of Cardiologists and Gastroenterologists. They have tended to get their own way, because they have a technique to sell. The authorities cannot understand what Diabetologists do all day, but we now have an opportunity to speak with one voice and to help members with local difficulties. John Wales has stressed the importance of 'networking' and, now that we all know each other, I hope that individual problems can be ventilated to everyone's advantage. If you have a problem or a good idea, do please write to the Newsletter.



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# Highlights of the ABCD Autumn 2001 Meeting

Dublin, Ireland, 22/23 November 2001



**Members of ABCD met to discuss the NSF for Diabetes and the roles and responsibilities of the Diabetes Specialist Nurse (DSN), to debate the clinical significance of postprandial hyperglycaemia and to update themselves through state-of-the-art lectures on other clinical issues.**

## THE NSF: IMPLICATIONS FOR SECONDARY CARE

The Chairman of ABCD, John Wales, pointed out that the final decisions on the NSF by the Secretary of State might not be the same as the recommendations of the Expert Group. The two key requirements for better diabetes care in the UK were more resources and more integration of care.

Dr Richard Firth (*Dublin*) said that in Ireland more diabetes resources were going to primary care (PC), which the Government thought was a cheaper option. Specialists in Ireland were concerned to achieve the following: type 1 diabetes to be managed only in the secondary sector; minimum diabetes standards to be set for GPs; all DSNs and Dietitians in the community to be attached also to Specialist Units.

## Contributions from the floor

**Redistribution of resources:** Shared/integrated care only worked well if it was structured. No-one knew where or what the money was presently. Maybe it was better not to have diabetes costed out precisely. Redistribution of resources would probably be by stealth. More PC diabetes would mean more demand for secondary care (SC). There was little difference in costs between the sectors.

**Motivation and training in primary care:** Currently GP diabetes referrals in Wolverhampton ranged from 20 to 80%. In N.Tees, there had been no differences in diabetes outcomes between three MAAGs, two involving 50% and one only 25% SC. In Basildon, GPs who had completed a one-year diabetes distance-learning course at Warwick were being given a financial incentive of £40 per patient. If a one-year Warwick course was enough, why bother to train as a specialist for seven years? Many GPs had no special interest in diabetes - the specialists had chosen diabetes. Should there be training programmes for GP diabetes specialists? In many places, it was the practice nurses who were delivering diabetes care. The RCP should address these matters urgently.

**Joint Specialist Society Clinical Effectiveness Forum:** Ken Shaw reported that the JSSCEF was looking to establish physician-specific professional standards as a basis of for an "annual Consultant appraisal and revalidation process". The RCP had submitted recommendations of good practice for acute physicians, comprising: good clinical care; maintaining good medical practice; teaching and training, appraising and assessing; relationships with patients; working with colleagues; probity; health. The third stage of pilot revalidation was to commence in February 2002.

## THE ROLES & RESPONSIBILITIES OF DSNs

Nina Essex described the piece-meal evolution of the DSN role in Croydon. Initially, the DSNs worked as a team, with close liaison between hospital and community. They were managed separately but clinically accountable to the Consultant Diabetologist. GPs had come to appreciate the enormous

benefits of DSNs and referred patients increasingly to them. At the same time, the role of the Community DSN had shifted towards PC and the relationship with the Consultant Diabetologist had become less clear. Clinical problems were routinely discussed with the Consultants, but not always objectives and working patterns, and there were sometimes areas of disagreement about working practice and accountability.

The following professional issues were identified: audit/monitoring of clinical practice; clinical accountability; the legal position regarding autonomous advice on medication; the implications of managing DSNs geographically. Dr Essex suggested the following ways forward: DSNs to be managed as a single team and to share a single base; objectives to be agreed jointly between non-clinical managers and clinicians; PC and SC to work closely together.

## Discussion points

About one third of delegates had experienced similar problems. Relations could be disrupted by Community DSNs being split between PCTs. There was no problem when they were employed by the hospital diabetes centre. Some PCTs felt they had more than enough to do already. In Birmingham Ladywood an initially forceful approach by the GPs had given way to a recognition of the importance of hospital involvement. Key words were seamless care and communications.

## DEBATE

**Motion:** "This House believes that the control of postprandial hyperglycaemia (PPBG) is an important part of diabetes management".

**For:** Charles Fox (*Northampton*)

**Against:** Dev Singh (*Wolverhampton*)

On a show of hands it was agreed that the result of the debate was a dead heat.

**John Wales concluded the meeting by thanking the following sponsors for their generous support: Lilly Diabetes Care; Novartis Pharmaceuticals UK Ltd; Servier Laboratories; Takeda UK Ltd.**

*Conference report by James Wroe*

## FORTHCOMING ABCD MEETING

**21/22 November 2002 – ABCD Autumn Meeting**

Hotel details: Euston Thistle Hotel, Euston, London, UK

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Email: [Euston@Thistle.co.uk](mailto:Euston@Thistle.co.uk),

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For registration and programme details contact:

Dr P Winocour, Queen Elizabeth II Hospital, Howlands, Welwyn Garden City, Herts, AL7 4HQ, UK

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RETIRING CHAIRMAN'S FAREWELL MESSAGE

“As others see us...through a glass darkly”

**John K Wales**  
Chairman, ABCD



**It is indeed a great pleasure to welcome the first issue of the ABCD Newsletter, which we hope you will find both interesting and informative about those topics which affect our work as Diabetologists, as well as about ABCD. Peter Daggett, James Wroe and his team are to be congratulated on their hard work to produce the Newsletter and I hope you will respond to our request for your comments and suggestions for future issues.**

As some of you will remember, ABCD was created at a meeting at the Royal College of Physicians in London in 1997. A number of Diabetologists at the time had become increasingly uneasy at the direction in which the representation of diabetes care in the NHS was being developed. Colleagues who had spent many hours and much energy developing their local diabetic patient care services felt their role was being devalued, taken for granted or just being ignored. Their heavy workload in general medicine did not appear to be acknowledged, compared to those specialities with high-profile, high-technology procedures and with easily measurable, auditable ‘clinical events’ and a high political impact. These views have not changed and remain a constant problem with which Diabetologists have to deal both locally and nationally.

Individual Consultants often feel that their local problems are unique to them. However, whenever Diabetologists met together it was clear that many Consultants were having similar problems across the NHS. There was no forum in which these problems could be discussed. It was clear to the founding members of ABCD that an Association was needed where Diabetologists could meet and feel comfortable in having open and robust discussions with their peers about clinical problems and the difficulties in the delivery of effective care in the NHS. These thoughts led to the creation of ABCD.

We had no infrastructure and relied on the good will of members and a little financial support. Our natural alliances are with the Royal Colleges. All members of the Association are Members or Fellows of one or more of the Royal Colleges and the Colleges represent the views of Consultants and trainees in all the medical specialities. ABCD has recently become a member of the RCP Diabetes and Endocrinology Speciality Committee and we hope that our representations there will be constructive and helpful to all Diabetologists and Trainees.

Our relationship with central Government and its agencies has expanded steadily. The Association has given both written and oral evidence to the Expert Group of the Diabetes NSF, to the Scottish NSF and Technology Board. Our submissions have been greatly strengthened by being able to draw on the comprehensive survey of specialist diabetes services in the NHS organised by Peter Winocour and to which members contributed strongly. We have been asked to nominate experts for the NICE assessments of topics such as long-acting insulins, diabetic patient education and insulin pumps. We have responded to the Government’s White Papers on the NHS, stressing the importance of long-term care, as in diabetes, as well as the role of Diabetologists within the NHS. For the past three years we have offered to help Diabetologists, members of the Association or not, who are

applying for Distinction Awards.

The possibility of joint meetings with the British Endocrine Societies has been reviewed regularly. We are keen, however, that any meeting, be it ‘joint’ or ‘back-to-back’, should be clinically orientated. We hope it will be possible to hold a back-to-back meeting with the Thyroid Society in November 2002, with both meetings open to both sets of members and with a joint dinner.

I would like to think that ABCD has maintained cordial relations with drug companies in the diabetes field. As Diabetologists, we are extremely lucky in having a number of senior people in the pharmaceutical industry who are supportive of the aims and aspirations of ABCD and who can see beyond the company horizon to the wider needs of the diabetes community. The Association owes them a debt of gratitude for their help.

The external relationships of the Association will only prosper if we have the respect of those we wish to influence, for the integrity of our views and the clarity with which we represent the views of all our membership. For this we need active members.

On a personal note, I have had the honour of being the Chairman of the Association for the first four years of its existence. However, I have retired in May this year, in part because I will retire from clinical practice at the end of the year and in part because new ideas and plans are always required and I feel ABCD is on the verge of important changes and new activities. With the determination of Richard, Ken, the Executive Committee and members, the Association has now established a foothold in the medical scene. We now need to attract more members, particularly younger Consultants and final year Trainees, to maintain our vitality, to strengthen our ability to give good and sustainable advice on the development of diabetic patient care in the UK, and to embrace objectively those new technologies which will make our patient care more effective. The Diabetes NSF could offer Diabetologists an important role in the future or give us very little. Together, we can make an impact to enhance and improve our ability to lead the improvements in diabetic patient care which are needed. If we are divided or apathetic, we will fail not only ourselves but also our Trainees, who represent the future, and our patients too.

I am sure the new Chairman will take up the challenges which lie ahead and, with the help of the Officers, Executive Committee and members of ABCD, move forward to secure a better future for all Diabetologists, the service and their patients.

**SEND US LETTERS, COMMENTS AND SUGGESTIONS**

Please send us your comments on this issue of the *ABCD Newsletter* as well as your suggestions for contents of future issues (initially twice a year). Or send us a *Letter to the Editor* or a contribution to the *Controversy* column.

Information about future meetings of interest to Diabetologists, for possible inclusion in the *Dates for your Diary* section, are also welcome, as are corrections to wrong addresses, notification of changes of address and news of new appointments in diabetology etc.

All communications to the *ABCD Newsletter* should be addressed to the Editor at the publishing address (see front cover).

# Highlights of the ABCD Spring 2002 Meeting



**Stratford Victoria Hotel, Stratford upon Avon, Thursday/Friday, 16/17 May 2002**

The well-attended Spring 2002 ABCD Meeting was marked by the sad occasion of the retirement of Chairman, John Wales (Leeds). The election as new Chairman of Richard Greenwood (Norwich), formerly Hon. Secretary, promised continuity in the Association's affairs. The new Hon. Secretary is Peter Winocour (Welwyn) and Ken Shaw (Portsmouth) continues as Hon. Treasurer. The following members were elected by ballot to join the ABCD Executive Committee: Brian Frier (Edinburgh); Jeremy Bending (Eastbourne); Steve Olczak (Boston); Anne Kilvert (Northampton); and T Blair (Northern Ireland).

## Chairman's Report

The Chairman announced that it was hoped to repeat the ABCD Survey of Secondary Diabetes Care in three year's time. A difficulty the Association faced in publicising the successful National Study Days was tracing SpRs, who moved every year; a reliable contact database would be very useful. Confirmation of ABCD's official representation on the Joint Speciality Committee for Endocrinology and Diabetes of the RCP was announced. ABCD had also been invited to have a representative on the Committee of the RSM Endocrinology Section. Jeremy Bending was the Association's official representative on the Diabetes UK Diabetes Care Advisory Committee.

The Chairman reported on the ABCD Distinction Award Support Scheme for the 2002 Round. It was felt that Diabetes was comparatively overlooked for Merit Awards by Trusts.

The following people had been granted Honorary Membership of ABCD, in recognition of their personal support for the Association: Jeff Goulder; Martin Jones; Peter Robinson; James Wroe. It was planned to hold future ABCD Spring Meetings in regional locations and Autumn Meetings in London.

## Hon Secretary's and Hon. Treasurer's Reports

ABCD had been invited to prepare formal submissions to the NSF and NICE Technical Assessments. It was gratifying to see how much progress had been made in such a comparatively short period. This was due in very large measure to the inspired efforts of the retiring Chairman, to whom Dr Greenwood paid warm tribute. Dr Greenwood expressed ABCD's thanks to Aventis, Novo Nordisk, Pfizer and Takeda for supporting the meeting.

In presenting the ABCD Accounts for the period 1 June 2000 - 31 August 2001, Ken Shaw pointed out that, on accountants' advice, the financial year of the Association had been changed. The Executive Committee had decided to maintain the annual subscription rate at the present level of £25.00. A separate bank account had been set up for the ABCD Charitable Trust.

## Future Strategy for ABCD

The retiring Chairman had prepared a paper on the future strategic direction of ABCD. He suggested that additional Secretaries should be appointed with responsibility for specific areas such as membership, publications, education, information, research and manpower. There was now a need also for a permanent secretariat, comprising a part-time secretary working in a London office facility.

Dr Wales suggested the following possible list of future ABCD activities: appraisal; monitoring the impact of the NSF; helping Diabetologists develop local services; peer review of local services. ABCD could play an important role, through the Charitable Trust, in facilitating good-quality clinical research by SpRs. Some projects might be undertaken in collaboration with

the MRC or the NHS or in association with pharmaceutical companies. Ways to raise the substantial funding required were being considered by the Trust.

## Discussion: Implications of the Diabetes NSF

Peter Winocour led a discussion on the ABCD response to the NSF Standards paper. While strongly supporting the aspiration of Standard 1 (*Reducing the risk of type 2 DM*), ABCD had pointed out that this would require a major change in society. On Standard 2 (*Identification of undiagnosed patients with diabetes*), ABCD believed that there was little point in large-scale population screening until the service structure to deal with the additional workload had been established.

ABCD endorsed in principle the "Shared care" approach to all patients with diabetes of Standard 3 but some practical difficulties were raised. Standard 4 (*High-quality care for all adult patients*) was a central objective for ABCD. One problem was the lack of interest in diabetes shown by most elderly care physicians. Another was the fact that Outpatient Departments were often "absolutely useless" for diabetes. Standards 5 & 6 (*High-quality care for all children and young people*): ABCD had expressed strong support for these. Should training in diabetes be mandatory in paediatrics? Standard 7 (*Management of diabetic emergencies*) was a central concern of ABCD. In many parts of the country, NHS Direct was the sole source of out-of-hours advice.

A propos Standard 8 (*Effective hospital care*), ABCD recognised that the management of diabetic patients admitted to hospital was frequently sub-optimal. There was a need to educate other specialists about diabetes. The recommendation that there should be ward-based DSNs was welcomed – providing there was funding. ABCD was also in favour of an integrated approach by Obstetrician and Diabetologist, as recommended in Standard 9 (*Diabetes in pregnancy*). This would involve extra sessions and therefore resources. With regard to Standards 10-12 (*Regular surveillance for long-term complications and integrated care for people with diabetes*), ABCD felt the one was essential and the other lacking in many localities.

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## DETAILS ON YOUR ABCD WEBSITE!

[www.diabetologists-abcd.org.uk](http://www.diabetologists-abcd.org.uk)



A full report on the Autumn 2001 ABCD Conference has been published in *Practical Diabetes International* Volume 19, Number 6 as well as on the ABCD website (address above), along with other interesting and useful information relating to the activities of ABCD and its members. If you have any comments or suggestions about the website, please contact the ABCD Website Officer, Bob Ryder on Tel No: 0121 507 4591 Email: bob.ryder@cityhospbham.wmids.nhs.uk

## Highlights of the ABCD Spring 2002 Meeting *continued from page 4*

**General comments and conclusions:** If the recommendations in the NSF Standards paper were fully funded, it would be difficult to fault them but ABCD should be represented on the NSF Implementation Group. Could lessons be learnt from the CHD and other NSFs? There would be no benefit if there were no more resources. There was a need for local prioritisation. All areas of diabetes care needed more resources - both PC and secondary care.

### Debate: "Evidence-based targets for control of diabetes are unrealistic in clinical practice"

#### Proposing the Motion

Melanie Davies (*Leicester*) said the barriers to achieving reductions in HbA<sub>1c</sub> - proved to reduce risk - were severe hypos and weight-gain. The reality of glycaemic control was nowhere near the target HbA<sub>1c</sub>s of 7.0% (ADA) or 6.5% (IDF). These had not been achieved even in a clinical trial environment and using various new pharmaceutical agents. There was no shortage of evidence of the benefits of antihypertensive treatment in diabetes but it was likely that only 1 in 8 patients was being treated adequately. Likewise lipids, smoking and weight. To sum up, Dr Davies said there was a wealth of evidence-based data to show how improvements could be made but huge interventions would be required to achieve these in practice.

#### Opposing the Motion

Bob Young (*Salford*) maintained that the reason we did not deliver evidence-based diabetes targets was because we did not organise to deliver them. The key was to change the way we did things. He presented data to show improvements achieved in Salford in the period 1993-2001 by using a stepped care approach and a system of small call centres checking up and prompting people. In summary, Dr Young said that real improvements could be achieved by embracing "system change".

#### Discussion

It was suggested that DoH targets could be used as a stick to beat health professionals (Dr Young pointed out that the targets had been set by peers). Nurses who were moving to call centre systems found the telephone contacts very stressful. The NSF Standards document did not mention Diabetic Registers. Dr Young said the new idea was to have a population-based data repository.

HbA<sub>1c</sub> and weight targets had proved much more difficult than BP and lipids. The patient's agenda should not be ignored; present technology did not permit glycaemic targets to be achieved without other unacceptable results, ie hypos, weight-gain. Perhaps there should be targets for informed decisions. There was a danger that HCPs could allow themselves to be judged by targets which were at the discretion of patients. How did one impart patient knowledge and understanding?

One member felt that part of the problem was the inclusion in the overall figures of very difficult patients, which skewed the data. Another delegate said the Salford results were impressive but what about the costs? (Bob Young replied that he would not have set up the study if he thought it would be unaffordable). It was claimed that patients did not like the major changes of therapy required to significantly reduce HbA<sub>1c</sub>.

**On a show of hands, the Chairman declared that the Motion had been carried, but by a reduced majority from the show of hands before the debate.**

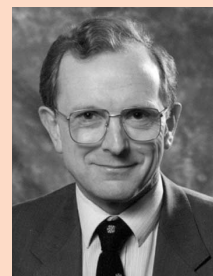
#### Other state-of-the-art lectures at the Meeting

**Diabetes and renal disease** – *Jitan Vora* (Royal Liverpool University Hospitals); **UKPDS - five years on** – *Rury Holman* (Radcliffe Infirmary); **Diabetes in the elderly** – *Alan Sinclair* (Walsgrave Hospital); **Management of hypopituitarism** – *Steve Shalet* (Christie Hospital); **Diabetic ketoacidosis** – *Sally Marshall* (Newcastle General Hospital)

*Conference report by James Wroe*

## New Chairman's Message

Having been involved with ABCD since its inception and having been Honorary Secretary for the first five years of its existence it is a great privilege and honour to become the new Chairman.



I should like to pay a warm tribute to our retiring founding Chairman, John Wales. It is largely due to his vision and determination that ABCD was established in the face of considerable resistance at the time. Since then with John's guidance ABCD has grown into a healthy and effective professional organisation. Happily the opposition has largely subsided and ABCD is now well established. We have achieved formal representation on the RCP Endo/DM Speciality Committee and we have been asked to submit evidence to the Diabetes NSF Expert Reference Group and several diabetes related NICE appraisals and guidelines.

Other recent ABCD contributions include the Survey of Secondary Care Facilities coordinated by Peter Winocour and support for diabetologists seeking higher merit awards. All of these initiatives were initiated and promoted by John Wales. Thus it is with great trepidation that I will attempt to follow him and strive to maintain our momentum.

I have enjoyed my time as Honorary Secretary and am grateful to colleagues for their help and support – especially Ken Shaw, the other member of the 'gang of three' – who has selflessly undertaken the demanding role of Honorary Treasurer. Largely due to his efforts ABCD is now in a healthy financial state and we have been able to underwrite and subsidise ten successful clinical meetings thus far.

I should also like to acknowledge the support of the pharmaceutical industry which has allowed us to alleviate costs for members and appropriately reward invited speakers who have been of a uniformly high standard.

I have now handed on the burden/reward of Honorary Secretary to Peter Winocour and would wish him well. In my view he hasn't got quite such a hard act to follow.

ABCD is now at a watershed. We are now well established and successful. However, we are in danger of becoming 'victims' of this success. Thus far, the three officers have in effect run ABCD in their 'spare time' with the help of our long suffering secretaries. There is now too much work for this 'ad hoc' arrangement to continue and we intend to establish a permanent secretariat in London within the next few months. This will make it much easier for us to administer the organisation and pursue ABCD's strategic objectives of supporting secondary care diabetes services and improving the management of all patients with diabetes.

The establishment of a proper infrastructure will be a leap forward for ABCD but it does mean that we will need an even more substantial financial base for the organisation. The officers and committee will be holding a planning meeting in the early Autumn to consider ABCD's future strategic development.

In the meantime the strength of ABCD depends entirely on its membership. At present about 40% of UK Consultants and a few final year SpR's belong. Please encourage your colleagues and SpR's to join. At £25.00 the annual subscription represents excellent value for money.

**Richard Greenwood**  
Chairman

CONTROVERSY

# What do we do about patients who default?

**Peter Daggett**  
 Editor, ABCD Newsletter



Every diabetic clinic has patients who default, some of whom do so on a grand scale. Sometimes this is welcome, because the clinics are over-booked or the patient is a 'heart sink' case. Occasionally, however, it is worrying, because of problems which do need to be addressed. Most specialists are not upset by one default, because all our memories are fallible, and they offer a new appointment. Two questions then arise. How many more appointments should be allowed before the patient is automatically discharged and how hard should we try to find out the reason for the non-attendances? 'Two strikes and out' seems to be a common rule but if a patient who needs to be seen complains to the GMC that he or she has been neglected, will the doctor in charge of the clinic be treated sympathetically? With the present regime, the answer is probably not.

There are several reasons why patients do not attend. Some just forget and such people usually telephone or write a nice letter to apologise. Some don't make the follow-up appointment at the clinic and some don't receive letters because of postal

failure. These are understandable and easily correctable. What is less easy to accept is the core of patients who just don't bother. This group probably accounts for half the defaults and the problem seems to be greater in diabetic clinics than in the general medical or endocrine services. We have all had the experience of a hale and hearty diabetic patient not turning up on the same day that a little old lady with severe heart failure struggles through the rain to get to the clinic on time. Chronic disease affects peoples' outlook on life, but it doesn't excuse rudeness. So what should we do to protect ourselves against charges of negligence brought by the feckless minority?

It would seem right to offer a further appointment after a first default. A second default is traditionally addressed by writing to the patient and copying this to the GP, but should rude people be treated with such consideration? There is much to be said for discharging them by default and, with the pressure on clinics, this should perhaps be the norm.

*Is there an issue you would like to air with your peers? If so, please send us a contribution for the Controversy column. Maximum 500 words, please. Address it to the Editor at the publishing address on the front cover.*

## MEMBERSHIP APPLICATION FORM FOR ABCD

### HOW TO JOIN ABCD

#### About the Association and Membership

The Association of British Clinical Diabetologists (ABCD) was founded in June 1997 to meet the perceived need for an independent forum in which Consultant Physicians could meet together and discuss specialist diabetic patient care in the NHS. ABCD feel the views of Specialist Diabetologists in the development of diabetic patient services have been overlooked and are important if the highest level of care is to be maintained and developed. ABCD is involved at present in three spheres of activity: meetings; training; and the organisation and delivery of patient care.

Membership of ABCD is open to all Consultant Physicians with an interest in diabetes patient care in the NHS and all SpRs in Diabetes and Endocrinology in their Final Year, ie post-PYA. At present, the annual membership fee is £25.00. This helps to reduce the cost of the six-monthly meetings for members as well as providing this newsletter. If you are interested in joining the Association, please fill in the application form alongside and return it to the Hon Secretary at the following address, to which all enquiries for further information about ABCD should also be sent:

**Dr Peter Winocour**  
 Consultant Physician  
 Queen Elizabeth Hospital  
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 Welwyn Garden City  
 AL7 4HQ

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When your application has been approved, you will be sent a Standing Order Form for your annual subscription.

### Membership Proposal Form

**I wish to apply for membership of the Association of British Clinical Diabetologists.**

Please use block capitals

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| Email                       |
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| Date                        |