



ABCD Newsletter

The Official Bulletin of the Association of British Clinical Diabetologists

Editor of ABCD Newsletter

Dr P Daggett
Consultant Physician
Staffordshire General Hospital
Western Road
Stafford ST16 3SA
Tel: 01785 257731
Fax: 01785 230773
Email: peter.daggett@msgh-tr.wmids.nhs.uk

Chairman of ABCD

Dr R H Greenwood
Consultant Physician
Elsie Bertram Diabetes Centre
Norfolk and Norwich University
Hospital, Colney Lane
Norwich NR4 7UY
Tel: 01603 286769
Fax: 01603 287320
Email: richard.greenwood@nnuh.nhs.uk

Hon. Treasurer of ABCD

Professor K Shaw
Consultant Physician
Queen Alexandra Hospital
Southwick Hill Road
Cosham, Portsmouth
PO6 3LY
Tel: 023 9228 6044
Fax: 023 9228 6822
Email: ken.shaw@porthosp.nhs.uk

Hon. Secretary of ABCD

Dr P Winocour
Consultant Physician
Queen Elizabeth II Hospital
Howlands
Welwyn Garden City
Herts AL7 4HQ
Tel: 01707 365156
Fax: 01707 365366
Email: pwinocourabcd@hotmail.com
or peter.winocour@nhs.net

ABCD Membership Co-ordinator

Dr J J Bending
Consultant Physician
Eastbourne District Diabetes Centre
Eastbourne District General Hospital
King's Drive,
Eastbourne
East Sussex
BN21 2UD
Tel: 01323 414902
Fax: 01323 414964
Email: jeremy.bending@esht.nhs.uk

ABCD Website Coordinator

Dr R E J Ryder
Consultant Physician
City Hospital
Dudley Road
Birmingham
B18 7QH
Tel: 0121 507 4591
Fax: 0121 507 4988
email: bob.ryder@swbh.nhs.uk

Publishers

John Wiley & Sons Ltd,
The Atrium,
Southern Gate,
CHICHESTER PO19 8SQ
Tel: 01243 779777
email: practical_diabetes@wiley.co.uk

© 2004 ABCD

Committee Members of ABCD

Dr A L T Blair
Consultant Physician
Tyrone County Hospital
Hospital Road, Omagh BT79 OAP
Tel: 028 82833578
Fax: 028 82833562
Email: tblair@slt.n-i.nhs.uk

Professor B M Frier

Consultant Physician
Royal Infirmary of Edinburgh
51 Little France Crescent
Edinburgh EH16 4SA
Tel: 0131 242 1475
Fax: 0131 242 1485
Email: brian.frier@luht.scot.nhs.uk

Dr I Gallen

Consultant Physician
Wycombe Hospital
Queen Alexandra Road
High Wycombe
Buckinghamshire HP11 2TT
Tel: 01494 526161 Bleep: 6589
Mobile: 07958456551
Fax: 01494425865
Email: lan.GALLEN@sbucks.nhs.uk

Dr C Hardisty

Consultant Physician
Room P19, Royal Hallamshire Hospital
Glossop Road
Sheffield S10 2JF
Tel: 0114 2712709
Fax: 0114 2713708
Email: colin.hardisty@stht.nhs.uk

Dr E R Higgs

Consultant Physician
Royal United Hospital
Coombe Park, Bath BA1 3NG
Tel: 01225 824991
Fax: 01225 824529
Email: eluned.higgs@ruh-bath.swest.nhs.uk

Dr J A Kilvert

Consultant Physician
Diabetes Centre
Northampton General Hospital
Cliftonville
Northampton NN1 5BD
Tel: 01604545576
Email: Anne.Kilvert@ngh.nhs.uk

Dr I G Lewin

Consultant Physician
North Devon District Hospital
Raleigh Park,
Barnstaple
Devon EX31 4JB
Tel: 01271 322417
Email: ian.lewin@ndevon.swest.nhs.uk

Dr S Olczak

Consultant Physician
Pilgrim Hospital, Sibsey Road
Sibsey Road, Boston
Lincs PE21 9QS
Tel: 01205 365801
Direct line: 01205 442099
Fax: 01205 356137
Email: stephen.olczak@ulh.nhs.uk

Dr C Walton

Consultant Physician
Diabetes Centre, Hull Royal Infirmary
Anlaby Road, Hull
East Yorkshire HU3 2RW
Tel: 01482 675368
Fax: 01482 675370
Email: Chris.Walton@hey.nhs.uk

EDITORIAL

Diabetes, the first tick box speciality

Peter Daggett
Editor, ABCD Newsletter

My favourite radio programme is "I'm sorry, I haven't a clue". Humphrey Lyttleton tells the teams that "points mean prizes". There is clearly a comedian at the Department of Health who has heard about this and decided that doctors can be controlled by the same approach. It is insulting to suggest that things will only get done if money changes hands, but unfortunately the notion has been accepted. The population is treated as a source of data, in the belief that the more we know about it, the healthier it will get. The concept of payment triggered by certain levels of compliance with Whitehall directives should be anathema. It is depressing, therefore, to see how many good doctors and their professional organisations are gleefully taking part. Woe betide the woman who declines a cervical smear, or the old man that says he doesn't want a flu jab. That's bad enough, but it's our

diabetic patients who have become the chief victims of the tick box culture. Over the years, diabetes has been largely ignored by health planners. Specialists all knew that complications could be prevented, but no-one in authority was interested, until large trials showed what could be achieved. The impetus to act was the implication that money could be saved by preventing complications. The problem was how to make sure that failure to deliver improvements could not be blamed upon the government. At some point, someone remembered "Lyttleton's law" and financial inducements were offered to practices that collected the most points. This is having many good effects, but we need to step back and see exactly what is being done. Records are being kept of

continued on page 2

This issue of the ABCD Newsletter has been supported by a non-restricted educational grant from Aventis

INSIDE

Editorial: Diabetes, the first tick box speciality	1
ABCD news and future meetings	2
Summary of ABCD response to NICE technology appraisal 63 on the use of glitazones	3
Highlights of the ABCD Spring Meeting	4
Controversy: Teaching the Teachers - who needs it?	6
Password-protected, members only, secure website	6
Chairman's Report	7
ABCD Website (Notice)	7
Problems of the diabetes speciality	8
ABCD Membership Application Form	8

continued from page 1

whether patients' eyes are being examined regularly, but not necessarily of what is wrong. It is good news that optometrists are examining more and more diabetics, but it does mean that doctors are becoming deskilled in recognizing retinal changes. I am ashamed to say that I no longer look in the eyes of all diabetic patients if they say they have been screened in the past 6 months and I doubt if I am alone. We know if feet are being looked at, but not whether those doing the looking understand what they are seeing. There are stories of examinations being performed through the socks and we have all seen black toes, a few weeks after an annual review. The serum creatinine is being recorded annually and I have just seen a nice sequence documenting deterioration into renal failure.

Unfortunately, no one understood what the numbers meant until it was too late. Minimal proteinuria, though, invariably produces a request for an urgent specialist opinion. Blood pressures are being recorded and patients are being reassured that 150 systolic is only slightly higher than that recommended on a sheet prepared by Diabetes UK – amazingly, that states it should be 140.

Patients on insulin are being told to come fasting to have their cholesterol checked, because no-one has the sense to realize that they will have a hypo on the way home. When the cholesterol comes back at 6.0, no action is taken, because the patient doesn't have any other risk factors. The concept of diabetics being "coronary equivalents" doesn't appear on the form. The biggest problem, though, is HbA1c. General Practitioners have been told that a majority of diabetic patients should have a level below 7% and are systematically increasing medication until that is achieved. Most specialists predicted the consequences of this and we have been proved right in spades. Patients gain weight and become hypoglycaemic. The majority of people with diabetes are elderly, and it is this group that is least able to tolerate a low blood glucose level. They collapse and have strokes or coronaries. Some may even die as a result of the quest to fill the quota of individuals who can be shown to have a perfect result. Put crudely, financial factors are affecting clinical judgement to the detriment of the diabetic population.

We should be talking to our patients and examining them rather than collecting data. Those who prefer stamp collecting, though, should apply common sense. I have just spoken to a colleague who is worried that a man of 85 on oral hypoglycaemics has an HbA1c of 8.5%. He feels perfectly well and has no diabetic complications, but he has had a series of TIAs. I explained that aggressive lowering of his blood glucose could lead to neurological problems and advised leaving well alone. "But the HbA1c is too high" was repeated parrot fashion and I was told that I must see the patient to put him on insulin. Why? It will do him no good. This then is what we have come to. GPs with their tick boxes and specialists with their experience. Few of us want to practice tick box medicine. That may be one reason for the recruitment and retention problems of our speciality.

ABCD news and future meetings

We all see adolescents, but few of us have much insight into their thought processes. Paediatricians are much more on their wavelength and a joint meeting has been arranged so that they can give us a few hints. This has been arranged in conjunction with the Royal Society of Medicine and will be held at the RSM on Monday February 21st 2005.

The next meeting of ABCD will be held at Jury's Hotel in Bloomsbury on Thursday and Friday, **November 11th and 12th**. As in the last two years, it will follow on from the autumn meeting of the British Thyroid Association at the Royal Free Hospital.

The Spring meeting of ABCD will be held in Harrogate on **April 6th and 7th 2005** and has been arranged to follow the British Endocrine Societies meeting. This is the first time that we have tried this arrangement; Harrogate in the Spring is a good venue and the conference centre is excellent.

A group of senior (old?) people have been musing about whether the life style advice that we give to our patients is followed by those who give it. There is a strong suspicion that it isn't and ABCD will be launching an anonymous questionnaire on the web site. It might give us pause for thought and it is to be hoped that everyone will complete it. It would be even better if they did so honestly!

Jeremy Bending and Bob Ryder have managed to get the list of members onto the secure, password accessible part of the web site. This means that every member can see who belongs and will be able to contact them more easily through their web site details. Also, if you spot someone is NOT a member and you think that they should be, you will be able to encourage them to join.

We have now reached the fifth edition of the Newsletter and I hope that you will agree that it is thriving. Some of you may think that I do all the work myself, which is not entirely the case. I would like publicly to thank James Wroe, who I am sure most of you know from his regular attendance at our conferences. His enthusiasm for ABCD and for the Newsletter has really been fantastic. What is less obvious, is the hard work of Helen Ilter, Tracey Curtis and Annette Patmore at our publishers, John Wiley. It is they who design and actually produce the final thing. It is also a pleasure to acknowledge the support of our friends Jeff Goulder of Novo Nordisk, John Dawber of Aventis and other generous patrons who will be mentioned in later editions. The fact that there will be later editions is down to all these colleagues. We are most grateful.

Summary of ABCD response to NICE technology appraisal 63 (August 2003) on the use of glitazones

Higgs ER, Krentz AJ on behalf of ABCD

Background

The National Institute for Clinical Excellence (NICE) published new guidance on use of thiazolidinediones (glitazones) in August 2003. Within days, the product licence of both available drugs was extended and this article summarises the ABCD response. It takes account of additional published evidence about glitazone use and the new licence.

Second-line therapy

NICE states that the principal use for glitazones is for patients in whom monotherapy with metformin or sulphonylurea has proved inadequate and who are unable to take metformin and sulphonylurea combination therapy.

ABCD recommendations:

- Consider a glitazone instead of metformin in renal impairment, since both glitazones are licensed in mild to moderate renal failure. Caution is needed in patients with nephropathy-related fluid retention or left ventricular dysfunction.
- Consider adding a glitazone to metformin as the preferred second-line therapy in obese patients (theoretical advantages in insulin-resistance).
- Glitazones should not be a substitute for insulin in patients with poor glycaemic control on maximum tolerated dose of sulphonylurea and metformin.

Monotherapy (3.3)

ABCD recommendation:

- Consider monotherapy with a glitazone when metformin is contraindicated or not tolerated, especially in obese patients (as per product licences).

Triple therapy

NICE does not offer clear guidelines on triple therapy with a sulphonylurea, metformin and a glitazone.

ABCD recommendations:

- There may be an occasional place for a trial of triple therapy, particularly in the very obese and those unwilling or unable to take insulin because of employment issues or other reasons.
- Care must be taken to avoid delaying insulin in patients who clearly need it.

Glitazone use, fluid retention and congestive cardiac failure

Oedema and heart failure can occur in patients treated with glitazones, particularly when used with insulin.

ABCD recommendation:

- Patients must be advised to monitor for oedema and breathlessness and to discontinue glitazones in these situations.

Use with insulin

Because of concerns about risk of heart failure, glitazones are currently contraindicated in patients on insulin in Europe (but not in the USA). However, using glitazones "off-label", some UK clinicians have found the combination useful in obese patients taking large doses of insulin; there can be improvements in blood glucose control and reduction in insulin dose.

ABCD recommendations:

- ABCD cannot currently recommend use of glitazones with insulin in the UK.
- If such use is considered, it is essential to screen for oedema, heart failure and significant left ventricular dysfunction and to ensure that the patient understands and accepts the increased risks.

Hepatotoxicity

To date, hepatotoxicity has not been observed with either glitazone; indeed improvement in liver function is sometimes reported. Furthermore, in non-alcoholic steatohepatitis (NASH), which is associated with insulin resistance, use of glitazones may be associated with significant improvement in biochemical and histological markers of liver disease.

ABCD recommendations:

- Clarification of the cause of hepatic dysfunction is important before glitazones are initiated in patients with abnormal liver function tests.
- Consider glitazone use in individuals with hepatic dysfunction due to NASH, with regular monitoring of liver function.
- Further studies are required to establish whether regular monitoring of liver function is clinically justified for glitazone therapy.

SEND US LETTERS, NEWS, ARTICLES AND SUGGESTIONS

Please send us your comments on this issue of the ABCD Newsletter as well as your suggestions for contents of future issues. Or send a Letter to the Editor or a contribution to the Controversy column. Information about future meetings of interest to Diabetologists is also welcome, as are corrections to wrong addresses and notifications of change of address of members.

Finally, the Editor is pleased to receive news of recent appointments in diabetology or of pending vacancies, which he will be pleased to mention in the Newsletter. All communications to the ABCD Newsletter should be addressed to the Editor at the publishing address (see front cover for details).

Highlights of the ABCD Spring Meeting

Manchester Marriott Airport Hotel, Thursday, 20 May 2004

At the Spring Meeting it was announced that membership will be opened up to all Specialist Registrars, the Executive Committee expanded to cope with the rapid growth in ABCD activities and a sophisticated new ABCD website developed. The meeting was supported by GSK, Novo Nordisk and Servier.

THE ABCD LECTURE: THE NEW CLINICAL EXCELLENCE AWARD SCHEME

Professor Sir Netar Mallick, Medical Director, Advisory Committee on Clinical Excellence Awards (ACCEA)

Sir Netar explained that the new scheme offers recognition and rewards for exceptional contributions to the Health Service (Table). Openness and transparency, clarity of criteria, equal opportunity and an intention that the awards should fully support the new NHS have been built in. There will be common assessment criteria and new Regional Sub-Committees (RSCs). The first eight of the 12 levels of award will be made by Local Awards Committees (LACs), the ninth level either nationally or locally and levels 10-12 purely nationally. LACs will include consultants, lay people, women and representatives of PCTs. Doctors will not be in a majority on the Central Committee of ACCEA. Candidates for awards can be nominated by themselves or another individual, a professional body or a LAC. The five domains to assess are Service Delivery, Service Development, Management, Research and Teaching. Successful candidates must demonstrate at least competence in the first of these for exceptional contributions in other domains to be considered. Service-related research and a substantial teaching contribution count as

supplementary evidence of overall excellence. A common system for scoring applications is being piloted

Points raised in plenary discussion

RSCs will not automatically include representatives of DGHS. The new assessment criteria are detailed and clear-cut and designed to ensure that those who excel in one or two things do not lose out. Writing review articles, leaders, textbooks etc is valued. Excellent researchers may be poor teachers, hence separate domains. It will be difficult to leapfrog levels. Testimonials should be clear and succinct with occasional negative comment if appropriate. Past achievements are relevant to a first application for an award but for higher awards only what has been done since the previous award. ABCD could help provide advice to members on the filling in of nomination forms which many find confusing. It was reported that in some Trusts people who have awards are being discriminated against for payment for extra work

THE ABCD DEBATE: COMPREHENSIVE MEASUREMENT OF MICROALBUMINURIA HAS NO PLACE IN THE ROUTINE CARE OF TYPE 2 DIABETES

Proposing the motion: Felix Burden (Birmingham)

The issue is not about GPs wanting to make money from the new GMS contract but administrators achieving 100% compliance with government targets. The relationship of heart disease and renal failure to albumin excretion rate is well evidenced, eg the Melton study (Figure 1). The commonest cause of death in diabetes (DM) is cardiovascular disease

KEY POINTS FROM THE 2004 AGM

- Richard Greenwood, Peter Winocour and Ken Shaw were re-elected as Chairman, Hon. Secretary and Hon. Treasurer.
- Membership, now comprising approximately two-thirds of UK Consultants, will in future be open to all 300 UK Endo/DM SpRs.
- ABCD representations to official bodies are increasing rapidly and the Executive Committee is being expanded to help with evidence, position papers etc.
- Four issues of The ABCD Newsletter have been published with the support of Novo Nordisk. The next four issues will be supported by Aventis.
- A new interactive website has been developed and will incorporate the membership database and a secure facility for discussion groups.

“to reward individuals who perform over and above the standard expected of a consultant in their post and who locally, nationally or internationally:

- Demonstrate sustained commitment to patient care and well-being or improved public health;
- Sustain high standards in the technical and clinical aspects of service whilst providing patient-centred care;
- In their day-to-day practice show a clear commitment to the values and goals of the NHS by participating actively in appraisal, annual job planning and observing the private practice code of conduct;”
- Are recognised as exceptional teachers and/or trainers and/or managers;
- Contribute to policy making and planning in health care.”

Table 1. Declared objectives of the new Clinical Excellence Awards scheme (Mallick)

Cases per million person-years per year - mean (95% CI)

- 35.6 (17 to 54.2) in white
- 486.6 (185.1 to 788.1) Indo Asian
- About 7 times non diabetes rates

Table 2. Incidence of ESRF in diabetes (*Burden*)

(CVD). When premature death is allowed for, the rate of end-stage renal failure is seven times higher in DM (Table 2). More evidence about outcomes and treatments, a change in attitudes and the ability to get treated are needed. We should case find, using locality-based testing, group education and treatment centres for impaired glucose tolerance and impaired fasting glucose subjects. The provisional two-year result of this approach in Birmingham Ladywood was a 10% reduction in the incidence of overt DM. In those who did develop DM, the percentage of diabetic patients with an acceptable systolic BP, cholesterol and HbA1c increased significantly. This is a more productive approach than comprehensive measurement of microalbuminuria (MA). Population-based screening of MA should only be adopted after other approaches to assessment and intervention have been used.

Opposing the motion: James Walker (Livingston)

MA affects 20%-25% of people after 10 years DM. It is the first sign of renal disease and a strong independent predictor of CV mortality and morbidity (Figure 2). It is easy to diagnose and is treatable (HOPE, IRMA II and Steno-2). With Steno-2 treatment for MA, a 64 year-old overweight person with type 2 DM and an ACR of 4.0-7.6 mg/mmol would have a 90% chance of RAS blockade, a 100% chance of a lipid-lowering drug and an 80% chance of aspirin. Elsewhere, the equivalent chances would be 60%, 30% and 50%. With Steno-2, he would have a 15% chance of reducing HbA1c < 6.5%, a 20% chance of reducing cholesterol < 4.5 mmol/l, a 50% chance of reducing systolic BP < 130 mmHg and a 70% chance of reducing diastolic BP < 80 mmHg. The equivalent chances elsewhere would be 5%, 20% and 60%. The chances of a CV event for him at eight years would be 24% with Steno-2 and 44% elsewhere. Failing to screen, diagnose and treat effectively MA was failing to protect against CVD and was at variance with accepted guidelines.

Points raised in plenary discussion

There was a danger of over-treatment of old people but biological age was more important than chronological age. Many GMS targets were age-specific. A negative screening result could be motivating and a positive result could promote lifestyle change. Twenty per cent of those population screened would not comply with treatment. There were attempts to exclude MA on the grounds of cost. If one did not screen, would one have to treat every patient according to Steno-2 care? It was important to know whether MA was rising but only if detection led to more aggressive treatment.

Diabetes in people aged over 65 kills fast – data before UKPDS or HPS:

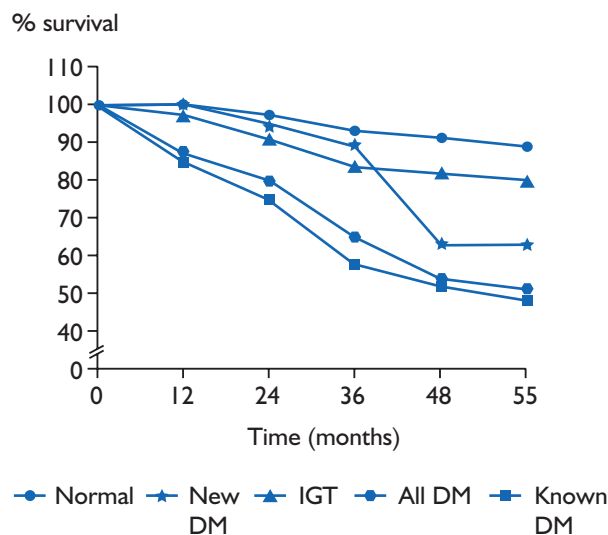


Figure 1. Mortality in diabetes: data from Melton study (*Burden*)

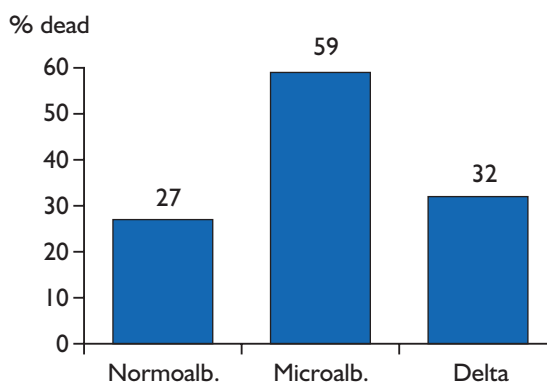


Figure 2. 10 year mortality and microalbuminuria (*Walker*)

The motion was defeated by 33 votes to 24, with two abstentions, a very similar result to the initial vote of 26 in favour and 33 against.

OTHER STATE-OF-THE-ART LECTURES AND CLINICAL AUDIT PRESENTATIONS AT THE SPRING MEETING

Presentation and management of male hypogonadism (*Dr Fred Wu, Manchester Royal Infirmary*); Management of difficult diabetic neuropathy (*Dr Solomon Tesfaye, Royal Hallamshire Hospital, Sheffield*); Sibutramine and metformin in the management of polycystic ovarian syndrome (*Dr Shirine Boardman, Warwick Hospital*); The role of diabetes healthcare technicians (*Dr Jonathan Roland, Peterborough Hospital NHS Trust*); Current and future management of diabetic heart disease (*Dr Clive Weston, Singleton Hospital, Swansea*); Transitional care: nothing ventured, nothing gained (*Dr Peter Betts, Southampton*).

Report by James Wroe

CONTROVERSY

Teaching the Teachers - who needs it?



Peter Daggett
Editor, ABCD Newsletter

I have been teaching students and junior doctors for some time, but a man wearing sandals and a floral shirt has come to tell me that I must go away to learn how to do it properly. My employer will pay the fee of £1,000, which I am assured is a bargain. The course is held at the local psychiatric hospital and on the first day the two “preceptors” are waiting for the group of consultants from all over the county. The big one with a beard has a large round badge that says Julian. This is to distinguish him from the little one in a dress whose even larger badge says Petunia. They explain that they are GPs with a special interest in teaching and have recently won the Golden Pile award. This is for making a video of their trainees telling patients they have haemorrhoids (the patients that is: first learning point - use unambiguous language). We are asked how we like to be addressed. I suggest “Sir”, but this does not go down well and I am immediately singled out. Now, Peter, we want you to pretend you are a blancmange. At this point, my mobile rings, because I have taken the precaution of asking my houseman to call me every hour, in case of just this sort of eventuality. I make my excuses and after a decent interval, return. I find that a paediatrician has smothered himself with pink face paint and is wobbling in the middle of the room. His colleagues are in stitches and the preceptors are delighted that they have such a committed bunch.

Next we are asked to form small groups, introduce ourselves to each other and report back. None of us knows what to say and after an hour of embarrassed silence, we tell Julian and Petunia that

we now know each other’s names. They beam and say that we have worked so hard that it’s time for lunch. It’s vegetarian – of course – and there is no alcohol. That might blunt our senses for the afternoon session, which as it turns out would have been a good thing. Julian puts down pieces of paper on the floor and marks them with arcane symbols. He and Petunia start to walk round them and I expect an appearance by Lucifer at any moment. No such luck – apparently they are going round the educational circle. They deliver a diatribe about the evils of didactic teaching, oblivious to the fact that their own discourse is didactic. By now, it’s four o’clock and time for our leaders to go, but they promise that they will be back tomorrow to give us some teaching practice. I have prepared a Power Point presentation on how to diagnose diabetes, but this is thought too simplistic. Instead, I am asked to give an impromptu description of how to make yoghurt. At this point my nerve cracks and I ask a question. Are you going to tell me anything useful, or can I go now? I am expelled, but I’m not too upset, because these twerps have spent two days explaining how to do badly what I have been doing well for 20 years.

Who decided to subject senior doctors to role-play and other kindergarten games? You can be sure that it was a group of academics, with the support of Regional Deans who haven’t seen the inside of a busy hospital for years and have no idea how we work. It is not hard to see what should be taught on these courses. We need to know how undergraduate and postgraduate examinations are being organised, so that we can tailor our existing skills to suit the needs of the candidates. We should be shown how to organise OSCEs and exactly what the PACEs system involves. We should be reminded how to set and answer multiple-choice questions and how to structure a lecture. Finally, we need instructions on how to mend Power Point when it goes down (but that might take a whole week). Some organisations have produced a two-day course like this, showing that it can be done. The left wing, intellectual air grinders who are still at large must be stopped.

Conflict of interest statement: I am a pogonophobe (look it up!) and I can’t abide trendy people with crackpot ideas

Password-protected, members only, secure website

Bob Ryder, ABCD Website Coordinator

The ABCD website has been overhauled (<http://www.diabetologists.org.uk>) and now features a twirling insulin molecule on its front page. A new feature of particular interest can be found by clicking “Members login” after clicking “Homepage”. This leads to a secure, password protected area exclusively for the use of members. It uses the latest “Sharepoint Team Services” technology which has been created by Microsoft to facilitate team working on the internet. Sharepoint technology is incredibly easy to use and there are extensive on line help facilities making it even easier.

This secure website could potentially allow ABCD to work collaboratively on various projects with great ease. There are two examples which will be activated in the near future. A form will be provided for members to enter details of cases where insulin was avoided by using triple oral therapy with glitazones. Similarly there will be a form for members to enter cases of successful use of glitazones with insulin in patients with insulin resistance. In both cases patient data will be completely anonymous so that there are

no ethical issues. In both cases by using the entire ABCD membership we should be able to accumulate rapidly a great amount of data on these two important subjects. Ian Gallen has set up a study of glargine in pregnancy and the form and explanation of this is available through the website.

Members could start thinking of other ways that the website could be used for collaborative working. There is a discussion area and it is suggested that anyone with an idea posts their idea there and this will invite comment. In the discussion area members can, if they wish, “subscribe” such that they are emailed whenever a comment is added to the discussion by another member.

A directory of all members with their details and email addresses is available in the secure website which will make it easier in future for members to contact each other. If members note that their details are wrong on the database they can email the membership secretary who will update the entry. In this way this central members database will be as up to date as possible. Gradually all ABCD documents will be stored in this secure area – minutes of meetings, draft and finalised position papers etc.

In the near future all ABCD members will be circulated with user names and passwords. For anything to do with the website contact bob.ryder@diabetologists.org.uk.



Chairman's Report

Judging by the reaction to my last "Chairman's Report", I am thinking of changing the name to "Chairman's Beef". I don't intend to be controversial and I am simply seeking to update members on the recent development of the Association. Be that as it may, the most sensitive issue I raised last time was the slightly tricky relationship between ABCD and Diabetes UK. This time I am pleased to report that encouraging progress is now being made in this area. Ken Shaw, Peter Winocour and I had a very constructive meeting in Birmingham with Sir Michael Hirst, Rudy Bilous and Benet Middleton. We reviewed a range of issues, which are of great concern to those of us working in secondary care. These included the implementation of the NSF, relationships with PCT's and, especially, problems with the recruitment of SPR's and Consultants in our speciality*. We agreed that urgent action is required to boost recruitment because failure to do so will have long-term and potentially serious adverse effects on the quality of diabetes (and endocrine) care. We felt that the increasing burden of acute general medicine is probably a major factor. No instant solutions were produced but we did agree to set up a joint working party to address these and related issues. There is no doubt that our ability to apply effective political and economic pressure on decision makers will be greatly enhanced by a joint effort by ABCD and Diabetes UK. We hope that this will be the first of many such collaborations and that we can thereby avoid some of the duplication of effort that has occurred in the past.

The other important bit of news is that at the Manchester AGM the Association agreed to change its constitution and to open membership to all SpRs training in endo/DM, not just final year SpRs. This agreement was preceded by a vigorous debate. Some members felt that this change could result in many more SpRs attending ABCD meetings, thereby radically changing their character, but the majority felt that, as the SpRs are the future 'life blood' of the Association, we should encourage as many as possible to join and attend meetings.

I am also pleased to report that the Association is restarting its SpR training meetings. The first of these is being organised by Gerry Rayman and will happen on Friday, 12th and Saturday, 13th November, immediately following the ABCD Autumn meeting. We are grateful to Eli Lilly for providing financial support for this initiative. Other planned activities include a joint meeting with paediatric endocrinologists at the Royal Society of Medicine on Monday, February 21st 2005, which will address the important topic of transitional care for young adults with diabetes and other endocrine problems.

The Spring meeting of the Association will be held in Harrogate on Wednesday, April 6th and Thursday, April 7th 2005. The reason for moving from our usual days of Thursday and Friday is that, for the first time, we will be meeting 'back to back' with the British Endocrine Societies. If the experiment is successful we intend to continue the arrangement, although it will necessarily limit our choice of dates and locations for the Spring meeting. At this point I would like to acknowledge

the continuing contribution of our Honorary Secretary, Peter Winocour, who has negotiated this arrangement and continues to organise excellent meeting programmes. The recent Spring meeting in Manchester achieved the highest overall score so far in the post meeting evaluation. He is now working on the programmes for the November London meeting, the February RSM meeting and the Spring meeting in Harrogate.

Nationally, diabetes does seem to be gradually gaining a higher profile, although there is, as yet, little evidence of additional resources for diabetes care. The report of a joint working party of the RCP, RCGP and NHS Alliance entitled "Clinicians, Services and Commissioning in Chronic Disease Management in the NHS" emphasises the importance of high quality diabetes care although it does use Ladywood as an exemplar and this model is not appropriate for all centres striving to achieve effective integrated care. The Joint British Societies are about to publish updated guidelines on the Prevention of Cardiovascular Disease. These now identify all diabetic patients as being high risk, which is helpful, but there is no clear distinction between Type 1 and Type 2 diabetes and no appropriate recognition of the high CVD risk associated with IGT and IFG. Regrettably, ABCD was not invited to contribute to this exercise but the participating societies do pay us the compliment of borrowing our initials for their BP management strategy!

Finally I would like to congratulate Eli Lilly on becoming the first Corporate Sponsor of ABCD. This is an important step forward for the Association and if, as we hope, other companies follow suit this will greatly strengthen our financial base and this should enable us to address more effectively many more of our objectives, especially in the areas of clinical research, audit and the generation of position papers on topical issues..

Richard Greenwood, Chairman, ABCD

**ABCD would be very interested in the views of members as to why this is happening and what can be done about it. How can we make our speciality more attractive to trainees? Answers to the Chairman on a postcard (or E-mail) please.*

DETAILS ON YOUR ABCD WEBSITE!

www.diabetologists-abcd.org.uk



A more detailed report on the ABCD Spring meeting appears in the September 2004 issue of *Practical Diabetes International* 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@swbh.nhs.uk

Problems of the diabetes speciality

Extracts from a letter from the Chairman of ABCD to the Chairman of the Scottish Diabetes Group

Our Chairman has been in correspondence with colleagues in Scotland and extracts from the text of a recent letter from him are printed below. This seems a very helpful encapsulation of our speciality's problems and it could prove useful when negotiating with your own PCTs.

Editor

1. Many well established high quality hospital-based specialist diabetes services are experiencing extreme difficulty, not only with attracting support for new and much needed developments, but also maintaining their basic infrastructure. The problems are greatest in those areas where there seems to be a poor relationship between the specialist service and local PCTs. Many PCTs not only do not appear to be interested in investing in hospital diabetes services, but they are also actively seeking to remove resources, eg specialist nurses, and re-deploy them in the community.
2. It is the Committee's view that a large-scale shift of specialist resource into Primary Care carries a high risk of fragmentation of the specialist service and professional isolation of the individuals concerned. This could carry a considerable clinical governance risk.
3. In many areas, the new GP contract is causing operational difficulties for specialist services. The quality payments associated with diabetes care are prompting GPs to demand more information about patients from specialist services, to refer more Type 2 patients if they fail to meet HbA1c targets and also to "case find" patients with early Type 2 diabetes in whom it is easier to meet performance targets. The latter phenomenon is in some areas leading to a surge in referrals to retinopathy screening programmes which is proving difficult to manage.
4. In many acute Trusts, diabetes services continue to attract very little interest and/or support from management despite the recent Diabetes NSF. This is because diabetes remains fairly low down the list of priorities, after elective surgery waiting times, the management of emergency admissions, cancer and coronary heart disease.
5. Many hospital-based diabetes services are finding it difficult to cope with the increasing burden of acute general medicine which is being devolved more and more onto diabetologists as other specialties, e.g. cardiology, withdraw from this area of work.
6. This increasingly onerous commitment may be one reason why specialist recruitment is showing an alarming decline in both numbers and quality of applicants. Another contributory factor may be the lack of private practice opportunities in our speciality compared with others. Whatever the reasons, this trend is deeply worrying.
7. The impending European Working Time Directive is going to have a major impact on SpR training. Many smaller Trusts will find it difficult to meet the requirements and may lose posts. In larger Trusts, most if not all SpRs will have to go onto full shifts. These changes could be very damaging to training programmes.
8. The new consultant contract could also damage diabetes services because many Trusts appear to be unwilling to pay for sufficient programmed activities to cover existing consultant workloads. This could well lead to large-scale cancellation of clinics, which would be very bad for patient care. ABCD is watching this development carefully.
9. There are a number of further uncertainties which may impact on the quality and quantity of diabetes services. These include Foundation Trusts (where chronic disease management does not appear to be a priority) and Patient Choice which may, in some areas, lead to a substantial increase in self-referrals to local specialist services which are poorly equipped to cope with any such increase in demand.
10. The final issue which has been raised is the relationship between diabetes and endocrinology. Although the two specialities are tending to diverge, ABCD feels that it would be very damaging if they were to separate completely. At present, about three quarters of UK diabetologists practice in both specialities and ABCD would wish to see this continue because any separation could result in both specialties becoming increasingly vulnerable.

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 ABCD Membership Co-ordinator at the following address:

Dr Jeremy Bending
Consultant Physician
District Diabetes Centre
Eastbourne District Hospital
Kings Drive, Eastbourne
East Sussex, BN21 2UD
Tel: 01323 414902
Email: jeremy.bending@esht.nhs.uk

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

Please note that all enquiries for other information about ABCD should be addressed to the Hon Secretary, Dr Peter Winocour (see contact details on front cover).

Membership Proposal Form

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

Please use block capitals

Name (in full, please)
Professional Qualifications
Position held
Address
Post Code
Tel. No.
Fax No.
Email
Signed
Date