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ABCD Newsletter

The Official Bulletin of the Association of British Clinical Diabetologists

EDITORIAL

Target Driven Training

Peter Daggett
Editor, ABCD Newsletter

The present cohort of trainees in our specialty will have an extensive knowledge of how to differentiate C11 from C17 hydroxylase deficiency and important management skills, such as the correct use of paper clips. Many of them will not, however, know as much about diabetes as they should. Training committees have forgotten that although rare diseases are interesting and teach us about physiology, they are not an integral part of the life of most endocrinologists. Neither is the taking of minutes at meetings, construction of financial spreadsheets or ensuring that rotas are compliant. True, someone has to do this, but surely we have enough managers for whom these tasks are the only purpose in life? Our trainees should be seeing diabetic patients in all their variety and complexity and they should be doing this every week. My present SpR will have missed a significant proportion of the available clinics because of insistence that he go to training days. When you then take out days lost because of night shifts, being on take or post take ward rounds, many more clinics are missed. Through no fault of their own, some SpRs are missing up to half of their clinics. That has a significant effect upon the consultants' workload but, more important, it will result in a group of doctors with their CCST, who will not have the necessary skills to run a high quality diabetic service. Previous commentaries in the Newsletter have expressed concern at the move of much diabetes care from specialist to general practitioner. Perhaps the disruption of training was anticipated, but might it be deliberate? If there were no properly trained diabetes specialists, there would be nowhere for patients to go, except to their GP. Fait accompli!

This scenario is of course a little paranoid, but unless the existing trainers do something, it may well come to pass. John Wass has told us in Harrogate that the pure endocrinologists do

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recognise the importance of diabetes in the training of junior doctors in our specialty. That is very welcome, because in the past, the training committees have been dominated by endocrinologists and they have rather different ideas from us of what is needed. That is why the curriculum includes an exhortation to know about MEN type 2B, a condition that I have seen once in 20 years. This is given the same emphasis as management of painful diabetic neuropathy, something that I see almost every week.

The books and forms that our SpRs have to complete result in target driven training. This is as damaging as target driven clinical work and in fact the two are mutually incompatible. Consultants can't achieve their targets if the SpRs are forever being taken away to be taught about super rarities, or to learn, for example, how to manage their own and others' anger. The old apprenticeship model, that was so effectively wrecked by Calman, did work. When, occasionally, a registrar could not get a senior registrar job, there was usually a good reason. Now, getting an NTN virtually guarantees a consultant appointment but, despite frequent assessments and reams of form filling, not all trainees are adequately trained by the time they get their CCST. So far, there has been very little progress in developing reliable measures of competency and that is regrettable.

A compromise between the new and old systems ought to be possible. First, it will be necessary to accept that service is a training environment and that the two are inseparable. Next, it must be acknowledged that diabetes constitutes at least 50% of their specialist workload for endocrinologists in DGHs. Finally, a sensible set of guidelines should be laid down and not a rigid curriculum. General diabetic and adult endocrine clinic work should be the core of training in our specialty, with occasional forays into other areas, such as paediatrics and gynaecology. A strict quota of "specialised" clinic work is unhelpful and often impossible to achieve. Study days should be planned 12 months in advance and should be in blocks. It might be possible to have two residential blocks each year, perhaps of up to three days at a time. At least 50% of the talks should be related to diabetes, with perhaps one talk on a management topic. This arrangement would allow clinics to be cancelled well in advance and also, allow duty rotas to be adjusted. All costs should be funded centrally. This is not really such a big change, but it would have great benefits for our trainees. Oh, and I really don't like to mention this: it might actually help consultants too.

CONTRIBUTE TO YOUR ABCD WEBSITE!

www.diabetologists-abcd.org.uk

Powerpoint presentations from the ABCD Spring meeting can be downloaded from the website. Please contribute to the ongoing ABCD nationwide audits and discussions on the current problems with specialist diabetes services. Take the opportunity to make comments or share clinical observations online.

ABCD website officer, Bob Ryder, can supply user name and password for the members only website.
Tel No: 0121 507 4591 Email: bob.ryder@swbh.nhs.uk

The ABCD Prize-winning SpR Project for 2004

Our congratulations to Dr Manish Khanolkar MRCP (Llandough Hospital, UK). He has kindly prepared the following synopsis of his prize-winning work. *Editor.*

Effects of rosiglitazone on platelet aggregation

Type 2 diabetes (T2D) is a cardiovascular disease (CVD) equivalent. Platelet aggregation represents an important early step in atherothrombosis. Thiazolidinediones such as rosiglitazone and pioglitazone are PPARγ agonists licensed for use in T2D. These drugs counter insulin resistance, a crucially important metabolic abnormality in T2D. Insulin resistance (with or without T2D) is known to be associated with increased platelet activation and insulin-resistant individuals have a significantly increased risk of CVD. We therefore conducted an in vitro study to assess the direct effects of rosiglitazone on platelet aggregation.

Whole blood was obtained in titrate tubes from 14 healthy fasting volunteers after confirming that none of them had consumed any drugs known to have anti-platelet effect over the preceding two weeks. This was diluted 1:1 with PBS (phosphate buffer saline) and transferred into 3 cuvettes (2 ml each) to be incubated at 35 degrees Celsius with DMSO (diluent for rosiglitazone, acting as control), 2μM rosiglitazone and 10μM rosiglitazone respectively for 40 minutes. Platelet aggregation was subsequently studied using whole blood impedance aggregometry (Chronolog). ADP (1μM) was used to induce platelet aggregation and tests were performed in triplicate. Increasing platelet aggregation between the two electrodes of the aggregometer produced increasing electrical impedance, which was displayed as a function of time on a chart recorder allowing its quantification in ohms. ADP-induced platelet aggregation was significantly reduced by incubating whole blood with rosiglitazone and showed a dose response relationship (Figure). Mean control value for platelet aggregation (n=14) was 20.42 ohms, reduced to 12.96 ohms in samples incubated with 2μM rosiglitazone ($p=0.015$) and a further reduction to 9.85 ohms was demonstrated in samples incubated with 10μM rosiglitazone ($p=0.006$).

This study demonstrates direct anti-platelet aggregatory effects of rosiglitazone. Furthermore, these anti-platelets effects occur with short pre-incubation periods (40 minutes) and show a dose response relationship. Recent studies have shown presence of functional PPARγ receptors in platelets, which may account for these direct effects of rosiglitazone on platelet aggregation. However, further mechanistic studies are required to explore the precise role of PPARγ in the platelet aggregatory cascade. Also, the clinical relevance of these in vitro anti-platelet effects of rosiglitazone needs to be determined. This study further supports the potential likely benefits of rosiglitazone therapy in reducing cardiovascular risk.

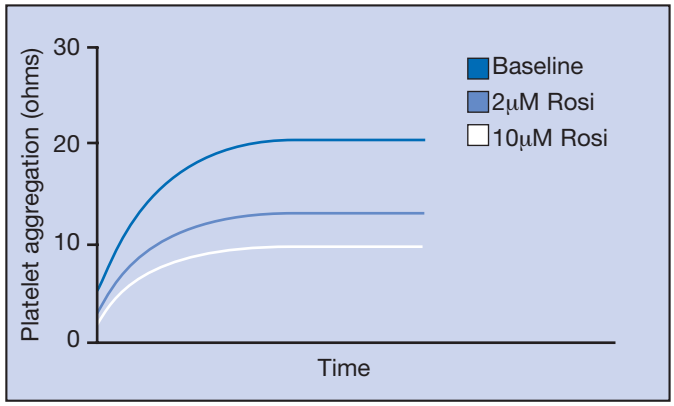

Figure. Dose response-related reduction in ADP-induced platelet aggregation from incubating whole blood with rosiglitazone

Highlights of the ABCD Spring 2005 Meeting

Wednesday, 6 April 2005, The Majestic Hotel, Harrogate

At the well-attended AGM, Richard Greenwood was re-elected as Chairman, Peter Winocour as Secretary and Ken Shaw as Hon. Treasurer. There has been a 16% increase in general membership over the past twelve months and a particularly rapid growth in SpR members. The meeting was supported by non-restricted grants from GSK, Eli Lilly and Novo Nordisk.

ANNUAL GENERAL MEETING

Richard Greenwood reported that ABCD position papers on glitazones and retinopathy screening published in *Practical Diabetes International* had been very well received. Further papers were being prepared on gestational diabetes, insulin pumps and diabetic ketoacidosis. A new Clinical Topics Sub-Group of the ABCD Committee had been set up to handle the increased volume of clinical and advisory report work, under the leadership of Steve Olczak. Regular meetings between ABCD and Diabetes UK were now taking place and the two organisations would jointly address key professional issues. The winner of the first ABCD Clinical Audit Competition, sponsored by Sanofi-Aventis, was Mike Sampson (Norwich), to carry out a national audit of diabetes inpatient services.

Peter Winocour said that 106 delegates had attended the ABCD Autumn 2004 Meeting. A successful symposium on transitional care had been held jointly with the Endocrine Section of the RSM in February and had attracted 243 delegates. A further meeting was planned. The present ABCD meeting was the first to be held back-to-back with the BES. At two ABCD meetings with the National Clinical Director for Diabetes, attended also by representatives of Diabetes UK, key objectives for specialist secondary care had been agreed.

Ken Shaw said the financial position of ABCD continued to be healthy. Four companies had now agreed to be Corporate Sponsors: Eli Lilly, Novo Nordisk, GSK and Takeda. More were in the pipeline. Professor Shaw expressed the Association's thanks. Consideration was being given to increasing the membership subscription, which had remained at £25.00 since the launch of ABCD.

THE ABCD LECTURE: "DIABETES AND ENDOCRINOLOGY: UNITED WE STAND, DIVIDED WE FALL"

Professor John Wass (Secretary, Society for Endocrinology) pointed out that 75% of diabetologists practised endocrinology but medico-political forces were tending to drive the specialties apart. The solution to the increase in patient numbers of transferring care to the GP was not underpinned by reliable research. The prevalence of some endocrine disorders was enormous, e.g. PCOS and osteoporosis. Agreement was required on which specialists handled what and which conditions should be dealt with by a DGH and which by a tertiary endocrine centre (Table).

Diabetologists were by definition very good general physicians. Unfortunately, only 10% of SpRs wanted to go into general medicine. A solution might be to do general medicine up to the age of 40-50 and then specialise. There should be shared initiatives by ABCD and the Society for Endocrinology, e.g. joint PG education meetings and recruitment days. In the past, BES meetings had tended to deal with rare conditions and it was now realised it was important to address common clinical conditions. Medical undergraduates needed to be taught about endocrine and diabetic disease. PR work was required.

THE ABCD DEBATE: "INSULIN THERAPY SHOULD BE THE TREATMENT OF CHOICE FOR TYPE 2 DIABETES COMPLICATED BY CHD"

Chairman: Dr Mark Savage (Manchester)

For the motion: Miles Fisher (Glasgow) said that low dose IV insulin should be given where there were clinical manifestations of ACS, if hyperglycaemic, to counter ketoacidosis. It was simple and safe to administer. In the case of patients with diabetes, it served additionally to prevent acute metabolic decompensation and to get potassium into the cells. DIGAMI 1 had shown significant benefits in HbA1c and mortality from 24 hours IV insulin/glucose followed by 3 months intensive insulin therapy. In DIGAMI 2, only minor differences in HbA1c were found between the study groups but Dr Fisher considered the study flawed. He suggested that all patients post-MI with hyperglycaemia should be given insulin according to the DIGAMI 1 protocol.

DGH	Tertiary endocrine centre
Thyroid disease	Cushing's disease
Prolactinoma	Pancreatic endocrine tumours
Non-functioning pituitary tumour	MEN
Hypogonadism	Thyroid eye disease
Hyperparathyroidism	Thyroid cancer (rare and complicated cases)
Osteoporosis	

Table. Where should endocrine conditions be managed? (Wass)

Against the motion: Simon Heller asked whether the high risk of CVD could be usefully controlled by tighter glycaemic control and successfully reduced by insulin compared to other agents and whether the benefits were outweighed by the side effects. There were a considerable number of potential adverse effects of insulin on CVD, eg intensive insulin therapy led in UKPDS and DCCT to an increase in body weight and hypoglycaemia. In the light of DIGAMI 2, it seemed reasonable to use acute IV insulin infusion without proceeding to insulin therapy, unless clinically indicated.

The motion was defeated.

ABCD SURVEY OF CARDIOVASCULAR RISK AND TREATMENT AMONGST UK CONSULTANT DIABETOLOGISTS

Peter Winocour reported on the results of a questionnaire sent to 620 Consultant Diabetologists, with a response of 187 (30% overall, 62% from members). The interesting findings included the following. The majority of respondents were middle aged white males who drank too much alcohol but rarely smoked. The majority undertook moderate exercise and had a reasonable intake of fruit and veg but over 25% ate too much red meat and added salt to food. 70% of respondents were unaware of their CVD risk score, 59% of their cholesterol level, 49% of their glucose level and 84% of their BP. There was a low use of CVD prevention Rx. In sum, said Peter Winocour, "do we practice what we preach – of course we don't!"

OTHER PRESENTATIONS

These included: Steve Hurel on continuous glucose monitoring systems; Marie France Kong on gastro-intestinal complications; Matthew Young on diabetic Charcot neuroarthropathy; David Matthews on emerging therapies for diabetes; and Ian Gallen on glargine use in type 2 diabetes and pregnancy (clinical audit).

See September issue of Practical Diabetes International *for a more detailed report.*

UK specialist diabetes services at the crossroads – moving in the right direction or heading into the wilderness?

Peter Winocour, Ken Shaw, Richard Greenwood

Introduction

The National Service Framework (NSF) for Diabetes was designed to improve diabetes care in all sectors. However, the lack of funding, together with initiatives linked to Agenda for Change and the increased emphasis on a primary care-led NHS, are adversely affecting specialist diabetes services. ABCD is concerned that the advent of Foundation Trusts, Payment by Results and Tariffs for outpatient visits will threaten efforts to improve services for patients and achieve integrated care. There will be particular problems for those acute trusts which reported sub-optimal service provision in the 2000 ABCD Survey (Ref). That suggested that 'success breeds success', so those services starting from a low baseline, might not receive sufficient additional support from Strategic Health Authorities to provide an acceptable level of service. In April 2005 ABCD invited reports of concerns and problems with diabetes services, especially those being damaged by negative Primary Care Trust attitudes. Responses have been received from all parts of the UK and some common themes have emerged.

Examples of inappropriate redeployment of specialist services from secondary care.

a) Transfer of patients attending specialist clinics, regardless of complexity, without there being an effective alternative clinical service This is to "improve" the new to follow-up ratio.

b) A unilateral decision to remove all podiatry from the specialist hospital sector.

c) Proposals to transfer hospital-based DSN services into the community, making it impossible to achieve the NSF standard of effective diabetes care in hospital.

d) Failure to replace retiring Diabetologists and embargoes on new appointments. It is not understood that most consultant diabetologists also provide services in acute medicine and endocrinology.

e) Threats to the maintenance and expansion of some SpR training posts, despite the need to provide adequate support for middle grade acute medicine and the specialty under the European Working Time Directive.

f) The removal of the extended specialist sessions from physicians, nurses and nutritionists that are needed to promote intensive self-management. This will affect the use of continuous insulin infusion pumps and DAFNE.

g) Widespread lack of psychology support.

Examples of lack of consensus planning by fragmented diabetes networks

a) Conflicts when specialists have to deal with several PCTs with differing agendas and which appear not to talk to each other.

b) Where services have been "pump primed" by charitable funding, PCTs are not picking up the costs as agreed and they are left in limbo.

c) Some centres with established retinal screening schemes prior to the NSF have been offered unrealistically low funding in order to fit within a limited cash envelope. This will make it impossible for them to meet the NSF targets.

d) PCTs often have unrealistic expectations regarding the capacity of rudimentary or hypothetical community care teams to manage the clinical diabetes workload. Provision is rarely made for clinical governance, which is a serious quality issue, when such teams are unsupported by properly trained specialists.

e) However, four centres commented that they were satisfied with current arrangements for the provision of diabetes services in their localities. The common thread from these centres was that there was effective collaboration with primary care and the specialist physicians had a strong role in the development of services in all settings. Success was more likely to be achieved when there was an informed network lead and a single commissioning PCT.

Failure to recognise the specialist role of the consultant diabetologist

a) There was broad agreement that specialists need to focus on complex cases and that it was necessary to afford these patients the time and expertise they require. However, it is also considered essential that hospital-based specialists play a leading role in service reconfiguration. They should have adequate time to develop the training and provide educational and clinical governance support for diabetes personnel operating in the community setting. This requirement is commonly ignored by both acute trusts and PCTs.

b) There was a strong prevailing view amongst hospital diabetes specialists that in many areas the current approach to commissioning diabetes services has followed a simple diktat that primary care developments would be the key to successful implementation of the NSF, regardless of the state of secondary care services. This may have led commissioners to overlook the problems of specialist services and to a failure to ensure the provision of all elements of diabetes care in both community and secondary care settings.

Conclusion

ABCD is convinced that the effective development of seamless quality diabetes care is critically dependent on adequate and effective specialist physician support. There should also be a full range of multidisciplinary input and competencies to provide the appropriate high-quality care in all settings. ABCD will be pursuing these issues with the National Clinical Director for Diabetes. Together with Diabetes UK, we shall be emphasising to SHAs and PCTs that active engagement of hospital-based specialist physicians in the planning and provision of diabetes care in all health care settings is considered vital, if the NSF targets are to be met.

Reference

Winocour PH, Ainsworth A, Williams R. Association of British Clinical Diabetologists (ABCD) Survey of secondary care services for diabetes in the United Kingdom, 2000. 1. Methods and major findings. Diabetic Med 2002; 19: 327-323

Consultant Appointments during 2004

There is concern within ABCD that hospital trusts will no longer find it necessary to appoint Consultants specialising in diabetes. The data below suggest that this is not yet a widespread problem but do confirm the problems of recruiting to our specialty. I am indebted to Linda Counter and particularly to Nina Newbery at the Royal College of Physicians of London for providing the raw data. Their interpretation is mine.

In the year ended 31/12/04, a total of 71 posts were advertised in England and Wales. Of these, three were withdrawn by the Trust concerned without explanation. A further 16 AACs were not held, because there were no applicants at all. Of the 52 AACs that did take place, no appointment was made in two, because the interviewees were deemed unsuitable. Thus, a total of 50 appointments were made. Four of these were in diabetes alone and the rest in the combined specialty diabetes and endocrinology. Twent-five of the posts interviewed were replacement posts and 27 new jobs. A total of six were academic posts, one at professor level. Two of these, including the professorship, were unfilled. A total of 76 candidates applied for the 52 posts interviewed, 1.46 applicants per post, with a range of 1 to 5.

Twenty-one out of 71 posts originally advertised remain unfilled (29.6%). The 76 candidates who were looking for jobs at the beginning of 2004 had the pick of 71 posts, giving a 93% chance of being appointed somewhere – pretty good odds. It means of course that there is presently very little competition for consultant posts in our field and that cannot be healthy. It is interesting to see which type of job was the least attractive. In contrast to former times, teaching hospitals and big cities seem to be unpopular. The new consultant contract may have something to do with the reluctance to consider an academic career and it seems likely that the quality of life and the cost of housing must be playing a part too. This brief snapshot does give cause for concern and it will be interesting to see the figures for 2005.

Peter Daggett, Editor, ABCD newsletter

ABCD Autumn 2005 Meeting

Wednesday/Thursday, 26/27 October 2005
Jurys Great Russell Street Hotel, London WC1

Programme includes:

- The ABCD Debate: HbA1c is not a sufficiently reliable marker of glycaemic control in diabetes care *(Proposer: Dr William Jeffcoate, Nottingham; Opposer: Professor Sally Marshall, Newcastle upon Tyne)*
- Roles and risks of continuous insulin pump therapy in type 1 diabetes *(Professor Stephanie Amiel, London)*
- Impact of oestrogen therapy on diabetes and vascular risk *(Dr Helen Buckler, Salford)*
- Tariffs for specialist diabetes services – the final nail in the coffin? *(Professor Tony Barnett, Birmingham)*
- Links between oxidative stress, inflammation and diabetic vascular disease *(Professor Naveed Sattar, Glasgow)*
- Anti-psychotic drugs and diabetes - genuine concern or industry hype? *(Dr Richard Holt, Southampton)*

Further details from: Elise Harvey, Gusto Events Ltd, PO Box 2927, Malmesbury SN16 0WZ. Tel 07970 606962. Fax 0117 904 7926. Email: elise@gustoevents.com

CONTROVERSY

What has gone wrong with modern medicine?

Peter Daggett
Editor, ABCD Newsletter

The medical profession has gone mad. We are giving powerful chemicals to whole groups of people, rather than thinking about the patient sitting in front of us. No one considers that what may be statistically right for a population, may not be biologically right for the individual. We are investigating all deviations from what is perceived as normal. We are operating on people because it is technically possible to do so. In short, we have been brainwashed by the peddlers of evidence-based medicine and as a result, we are frequently acting against patients' best interests.

Cardiologists have conducted trials of many different drugs and it is not unusual for a previously healthy person to leave hospital taking 6 different ones. Fortunately, a dictum of a surgeon that I know is true – "patients who say they are taking more than 5 drugs, aren't!" Rheumatologists use an array of toxic substances and many of my medical admissions result from their activities. Gastro-intestinal bleeds, renal failure and the complications of immuno-suppression are seen regularly. Then we have diabetics with a high haemoglobin A1c level. Medication is increased progressively, until the target is reached and the consequences are weight gain and hypoglycaemia. I rely on sophisticated investigations, but how many tests are needed as a routine? If a middle-aged man develops paroxysmal nocturnal dyspnoea, ankle oedema and bilateral basal crepitations, he probably has heart failure. Why must we perform cardiac ultrasound to prove it? A lady who has visited a rheumatologist complains of dyspepsia and is found to be anaemic. It is likely that she has NSAID induced bleeding from the stomach, but she may get a colonoscopy as well as a gastroscopy, because the gastroenterologist once saw a case of caecal carcinoma in a patient with a peptic ulcer. It's good practice, but is it good for the patient? Many of my friends are surgeons. They are all highly skilled professionals, but some have lost sight of the fact that there is a patient attached to the part they are operating on. It is not sensible to repair a hernia in a patient with severe heart failure, nor is it wise to perform carotid endarterectomy in a patient with advanced emphysema. In both cases, a prolonged stay in the ITU (or worse) should be anticipated. It takes many surgeons about 20 years to appreciate this, by which time, they are about to retire and the next generation starts again, with its own delusions of invincibility.

How have we reached this point? I blame mega-trialists, meta-analysts and medical teachers who have forgotten (or who never knew) that high tech is not necessarily good tech. It all boils down to common sense, something that cannot be taught and which appears to be in short supply. If clinicians approaching retirement had less direct patient involvement, younger colleagues could use them as a reservoir of wisdom. This could be dressed up as a form of audit, something that managers and politicians would applaud. I wonder if any organization has the courage to suggest this?

Chairman's Report

So, what's been happening since the last Newsletter? The answer is - quite a lot. The Association's corporate sponsorship scheme has now taken firm root. We are most grateful to Eli Lilly, Novo Nordisk, GSK, Takeda and Sanofi-Aventis, all of whom have made generous contributions. This will give us greater financial stability and, as a result, our Treasurer will no longer have to go around the companies with his begging bowl for each meeting (although Ken is rather good at it and it's an invaluable skill).

Our membership has grown 16% in the past 12 months and we are particularly pleased to welcome over 60 SpRs. In recognition of this, we shall be co-opting an SpR representative onto the ABCD committee, which will see some other changes. We welcome Jiten Vora and Dinesh Nagi as new members, while Brian Frier and Anne Kilvert have been re-elected. Steve Olczak will be leading a Clinical Topics Sub-Group, to coordinate our responses to the ever-increasing number of national initiatives, such as NICE Guidance and Health Technology Assessments. This Sub-Group will also commission further position papers on behalf of the Association. Following the publication of the ABCD paper on the rational use of glitazones (written by Andrew Krentz and Lyn Higgs), I am pleased to report that the Medicines and Healthcare Products Regulatory Agency (MHRA) has now acknowledged that it is appropriate for specialist diabetologists to use insulin and a glitazone in combination, providing the patient is fully informed and carefully monitored for signs of fluid retention and heart failure. This is a real step forward and should help us to manage some of those difficult patients with severe insulin resistance who are poorly controlled on large doses of insulin.

The joint ABCD-RSM meeting on Transitional (Adolescent) Endocrinology and Diabetes on February 21st was a great success, with over 200 delegates, and we are hoping to repeat this model, possibly with a joint ABCD-RSM meeting on the management of endocrine disorders and diabetes in the elderly. I am sure that this will be of considerable interest to many members of the Association, especially myself *(surely not – Ed.)* Our first back-to-back meeting with the British Endocrine Societies in Harrogate in April went well and we will be repeating this arrangement in Glasgow next spring. If this pattern becomes the norm, though, we could find our choice of spring venues limited to Birmingham, Bournemouth, Harrogate and Glasgow. That would be a pity, as I have fond memories of earlier ABCD meetings in Windsor, Edinburgh, York, Stratford and, especially, Amsterdam. Our Autumn Meeting will be back-to-back with the British Thyroid Association, but this year the BTA will meet on Wednesday, October 26. We will therefore be meeting on Wednesday and Thursday, October 26-27 and the SpR Training Days will follow the main meeting. Those dates will be Thursday and Friday, October 27-28 and they will be supported by Eli Lilly. Our grateful thanks to them and to the organiser for ABCD, Gerry Rayman. This year, he will be aided and abetted by Geoff Gill, who will be bringing the best of his Liverpool SpR meeting to the south. We are very much looking forward to this exciting collaboration, which we hope will capture the best features of both programmes.

During the gathering of Diabetes UK in Glasgow in April, we had our second liaison meeting with them. This was much more constructive than the last one and we have agreed to work together to address a series of current issues, including faltering recruitment to the speciality and the potentially disastrous effect of 'Payment by Results'. We will be jointly sponsoring a repeat of Peter Winocour's 2000 survey of specialist services, which had such a big impact on the NSF. This should give us a clearer picture of progress (or lack of it) towards achieving the NSF objectives. Sadly, this continues to be hindered by national and local politics. We are receiving further reports of specialists struggling to cope with PCT and Trust indifference to essential developments, such as pumps and DAFNE. We have also heard of serious attempts to shift specialist resources into primary care. I would like to reiterate that the Association will continue to make every effort to resist these damaging 'initiatives' and to support individual members who find themselves and their services in difficulties as a result because, in our view, it will not be possible to achieve good diabetes care without strong local specialist support

Richard Greenwood, Chairman, ABCD

MEMBERSHIP APPLICATION FORM FOR ABCD

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. At present, the annual membership fee is £25.00. If you are interested in joining the Association, please fill in the application form below 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.

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