



ABCD Newsletter

The Official Bulletin of the Association of British Clinical Diabetologists

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EDITORIAL

Diabetes research - is it sicker than the patients?

Peter Daggett
Editor, ABCD Newsletter

Diabetes is common. Diabetologists spend a lot of time thinking about the condition. There are five chairs of diabetes in the UK and the holders of several other chairs of medicine are primarily interested in diabetes. A recent issue of "New Scientist" contained 32 pages of available PhD and post-doctoral posts, none of which were in the field of diabetes. The last statement is surprising in the light of the first three and requires an explanation.

At present, academic activity in our specialty falls into two main categories. First, there is research in basic science and this is funded mainly by charities. We thus know a lot about such things as incretin hormones, nuclear receptors for novel drugs and the molecular biology of GLUT 4 and the like. This is interesting, but not much use to patients, who want better and easier ways to control their blood glucose levels. It is argued that we can't have developments without

knowing the scientific basis of what we do and that is true, but I wonder if we are in danger of not being able to see the broader picture through our obsession with minutiae. Second, we have what might be called macro-diabetes studies. These are more likely to be supported by central government and local initiatives. They attempt to improve (or should that be control?) patients' lives with such things as DAFNE and DESMOND, but these projects do not lend themselves to the sort of research that would attract a physician with a scientific turn of mind. I don't know many young doctors who would elect to enter this field and in fact many of the investigators are quite senior and perhaps, past their most creative phase. UKPDS was an exception, but all the "science" was done in one centre and the

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foot soldiers who collected the data were not really researchers at all. UK diabetes research is stuck in a 10-year cycle, with pretty much the same topics being presented at meetings in 2006 as in 1996 and 1986.

There are several possible reasons for this, but the main one is that diabetes is huge in population terms, but actually quite small in research terms. There are thus too many people doing the same thing, each attempting to outdo the others and none achieving anything really new. Papers are produced on the principle of “publish or be damned” and most of the articles that appear in the diabetes journals are no more than pot boilers. This is the British way, where anyone who can get funding can have a go at research, but surely, it is a waste of resources? Some competition of course is needed, to prevent stagnation, but do we really need centres in six different cities studying, for example, “novel” hormones and cytokines. That is what appears to be happening now, as judged by poster presentations at a recent meeting. Although this may be anathema to many, what is sorely needed is some central advisory body that could identify clinically important problems and allocate projects to two or three groups. The MRC might have a role here, ensuring that money could be diverted to a small set of researchers who know what they are doing, but who have the stimulus of some competition. Penalties could be imposed for publishing papers just for the sake of it and selection for this might form the subject of an interesting session at meetings of ABCD. The other prime reason for the duplication of research is that there are too many research fellows and these individuals have to be found something to do. A bee in the boss’s bonnet is seldom a good basis for worthwhile research. Rather than academics advertising for people to service their MD machine, it would be better to match aspiring researchers and available jobs centrally, as is now being done for F1 and F2 posts.

Here are some suggestions for areas of research that require a big push, two in basic science and the other in clinical epidemiology. A reliable transcutaneous glucose sensor is high on the list, allowing real time monitoring and the alerting of patients to hypoglycaemia. Next we need an implantable sensor that could be linked to a microprocessor

and subcutaneous insulin pump. We would then have a workable artificial pancreas. Finally, we should re-examine the sacred cow called HbA1c and ask if this really is the only way to assess long-term control. Many patients now have meters that produce average blood glucose results over one day, one week and longer. It may be that such data will do the same job as HbA1c.

In order to solve the problem of glucose sensing, it would be wise to involve departments of chemistry and biophysics, which is perhaps why few departments of medicine in the UK are looking at this area. It is not in the interests of medical academics to put work the way of other disciplines, but a central authority would have no such inhibitions and the right people might be asked to deal with the matter. The question of HbA1c would require a large number of patients and long-term studies, almost a UKPDS mark 2. This could be undertaken by medical researchers in two or three centres co-operatively. We have in this country some of the best medical brains in the world, but they are not being used to best effect, because of the traditional British way of doing things. At present, there is a tendency to say, “here is a new test or technique: let’s see what we can use it for”. What we should be saying is, “here is a problem: how can we solve it?” Doctors should look after patients and not test tubes. Few of us can do both, which is why so many good young clinicians produce so much fairly tedious science. The senior people should be able to tell when a project is going nowhere and stop it before a lot of time, effort and money is wasted. Too often, the team leader tells the trainee how to pad out a piece of work that contributes little to science and worse, which journal is most likely to publish it. The paper chase is won, but the patients still have diabetes and are still developing complications.

CONTRIBUTE TO YOUR ABCD WEBSITE!

www.diabetologists.org.uk



Powerpoint presentations from recent ABCD meetings can be downloaded from the members only, password protected, website. Any member can easily use the Sharepoint technology underpinning this area of the website to set up nationwide audits.

Discussions can also be easily set up.

ABCD website officer, Bob Ryder, can supply user name and password for the members only website and also advise on the above.

Tel No: 0121 507 4591 Email: bob.ryder@diabetologists.org.uk

ABCD AUTUMN 2006 MEETING

2 November 2006 Hotel Russell, London

Lectures featuring at the conference are:

Dr Hugh Jones: Androgen replacement therapy should be considered in management of men with type 2 diabetes.

Dr Martin Hadley Brown: The contribution of specialist services to integrated diabetes care – The GP perspective.

The ABCD Debate – Diagnosis of the Metabolic Syndrome adds nothing to the care of patients with or at risk of type 2 diabetes and CVD.

Proposer: Professor Edwin Gale. Opposer: Professor George Alberti

Dr Peter Watson: All you ever wanted to know about Coeliac Disease but were afraid to ask!

Dr Simon Griffin: Screening for Diabetes – who, when, how and if?

Dr Paul Dodson: Impact of medical therapies on diabetic retinopathy.

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Diabetes specialist care – the changing role of the consultant diabetologist

RICHARD GREENWOOD

Introduction

Diabetes care in the UK is evolving rapidly, with the emergence of new models of service delivery and diabetes specialist care workers. These developments are challenging the traditional structure and leadership of established diabetes services. The Diabetes National Service Framework Delivery Strategy re-emphasised the importance of the specialist diabetologist¹, but the proliferation of new types of diabetes care professionals has led to confusion about leadership and what is now meant by the term 'diabetes specialist'.

Background

Historically, most UK hospital diabetic clinics have catered for patients with both Type 1 and Type 2 diabetes. In the 1970's alternative systems such as Shared Care (Poole) and GP Mini Clinics (Wolverhampton) were developed. At about the same time, the role of the diabetes specialist nurse (DSN) became established. Patient education became a priority and this led to the development of specialist diabetes centres. These not only provided an integrated multidisciplinary approach to specialist care, but also allowed more effective coordination of district diabetes services.

More recently there has been increased emphasis on developing diabetes care in general practice, in line with the government's desire for a 'primary care-led' NHS. The recently published White Paper insists that the management of chronic diseases including diabetes should be shifted from acute hospitals into the community². This process will doubtless be accelerated by the introduction of Payment by Results and Practice-Based Commissioning. Regrettably, many PCT's are already reducing support for specialist services and this is damaging local diabetes units. There is general agreement that this is not in the patient's best interests (see the recent Joint Position Statement from Diabetes UK and ABCD³).

However, it is clear that whatever happens, some patients will still need the support of an accredited diabetes specialist. These include children and adolescents, women who are pregnant or planning pregnancy, patients with unstable Type 1 diabetes, those requiring new or complex therapies, e.g. insulin pumps or inhaled insulin, or with serious complications, e.g. retinopathy, nephropathy and foot problems, and patients with rare types of diabetes such as those associated with cystic fibrosis and pancreatic and other endocrine diseases. This list is derived from the DoH guidelines for the appointment of GPs with a Specialist Interest in Diabetes⁴ and the Diabetes UK "Recommendations for the Provision of Services in Primary Care for people with diabetes⁵". For other patients there is considerable variation in the delivery and quality of care. In 1999 the BDA stated that: "It is essential that all people with diabetes receive equal access to comprehensive care of high quality". Diabetes care may be delivered by a variety of providers in a range of different settings. Thus the pattern of service provision will vary from locality to locality, particularly in relation to the proportion of patients relying entirely on the specialist hospital service, those receiving

their planned follow up by general practitioners and their staff, and those receiving "shared care"⁶.

What is a Diabetes Specialist?

It is not surprising that there is confusion as to what now constitutes a diabetes specialist. The most easily recognised specialist is still the consultant physician (diabetologist) who holds a Certificate of Completion of Specialist Training (CCST) in Endocrinology and Diabetes. This obliges the trainee to:

1. Hold a UK-recognised medical degree, e.g. MB BS.
2. Have passed the MRCP or an equivalent specialist qualification.
3. Have completed an approved training programme in a recognised training centre(s).
4. Have satisfied annual (RITA) assessments of in-service training.
5. In most instances, to have gained a UK consultant post through open competition.

Details of the specialist training curriculum can be found on the JCHMT website⁷.

What are the historical roles and responsibilities of the Specialist Diabetologist?

The consultant diabetologist generally leads a hospital-based multidisciplinary diabetes team, which is responsible for delivering a comprehensive specialist service. This includes initiating appropriate treatment in patients with newly diagnosed diabetes, ensuring that patients are provided with appropriate educational and psychological support, monitoring diabetes control and adjusting therapy to achieve agreed treatment goals and ensuring that patients are regularly and effectively screened for complications. The diabetologist is responsible for ensuring that patients suffering from acute complications including ketoacidosis, hypoglycaemia and foot problems are managed safely. They are also responsible for referring patients to other specialities including ophthalmology, nephrology, vascular surgery and cardiology when necessary. They work closely with obstetricians to provide expert care for pregnant women with diabetes and with paediatric diabetologists to optimally manage transitional (teenage) patients. Other responsibilities include teaching nurses, medical undergraduates and postgraduates about diabetes and its management and developing acute and community diabetes management guidelines. They are often involved in implementing and leading district wide services such as screening for diabetic eye disease, undertaking and - supporting diabetes research projects, developing and providing community diabetes services, supporting local branches of Diabetes UK and helping local charity fund-raising initiatives to provide resources and facilities not available from the NHS.

Other Roles of the Consultant Diabetologist

Endocrinology

Most consultant diabetologists provide a specialist endocrine service. There are a lot of patients with thyroid diseases, many of which are difficult to manage. Many consultants are licensed to prescribe radioiodine and most perform thyroid biopsies.

They work closely with ophthalmologists to treat thyroid eye complications. They collaborate with gynaecologists in the management of patients with polycystic ovary syndrome and infertility. They manage patients with uncommon endocrine disorders such as acromegaly and Cushing's syndrome requiring access to specialist endocrine facilities.

General medicine

Most diabetologists participate in the general medical intake. As other specialities move away from general medicine, the diabetologist's role is becoming increasingly important. The multi-system nature of diabetes training means that diabetologists are well equipped to deal with general medical problems, especially those not easily mapped to other specialities.

Specialist Diabetes Manpower Issues

Currently the UK has about one consultant diabetologist per 100,000 of the population, but it is estimated that there should be twice as many⁸. It will be difficult to achieve this due to financial constraints and a shortage of suitable applicants for consultant and trainee posts. Therefore it is important to support the development of specialist skills in primary care. However, it is essential that all diabetes healthcare workers are adequately trained and competent to deliver a high quality, safe service. At present many of the new roles are not underpinned by formal training programmes or recognisable qualifications. This is a governance issue and is a cause for concern.

Other Specialist Staff

Who are these other diabetes 'specialists'? They include specialist registrars, associate specialists, staff grades and clinical assistants who work mostly in hospitals under the direction of consultant diabetologists and Diabetes Specialist Nurse (DSN)'s. However, at present, DSN's do not have any formal diabetes specialist qualification, although some are training to become nurse prescribers and this should support their specialist care role. There are also some higher-grade Nurse Consultants and Community Matrons, but in many instances there is confusion about their precise roles in specialist diabetes care. In primary care there are now General Practitioners with a Special Interest (GPwSI) in diabetes. At present no formal specialist qualification is required for this role, but a period of consultant-supervised training is recommended⁵. Most community diabetes care is delivered by practice nurses. The majority do an excellent job but few have had formal training in diabetes, although some have done the ENB 928 or Warwick courses. Other key diabetes staff include dietitians, podiatrists, psychologists, optometrists and pharmacists. These groups are all professionally qualified but at present no formal specialist training or qualification in diabetes is required.

Conclusions

Effective diabetes care is critically dependent on multidisciplinary team-working. At present, the consultant diabetologist is the only member of the team who has undertaken formal training and gained accreditation in the speciality of diabetes. This has quality and governance implications. Their skills, experience, enthusiasm and commitment mean that diabetologists are ideally qualified to lead the development of integrated care and the

achievement of NSF targets. Moreover, the need for strong specialist support has recently been emphasised in a review of the implications of the Quality and Outcomes Framework for primary care diabetes services⁹. Thus the role of diabetologists is changing. Nevertheless, they are still essential for the provision of specialist support for acutely ill and complicated patients, specialist endocrinology and acute general medicine. For these reasons most will remain predominantly hospital-based. It should be obvious that they will need adequate support to enable them to fulfil their various roles and this must be recognised by local NHS management.

References

1. National Service Framework for Diabetes. Delivery Strategy. Department of Health, 2002
2. Our health, Our care, Our say: a new direction for community services. White Paper, Jan 2006
3. Ensuring access to high quality care for people with diabetes. Joint Position Statement, Diabetes UK and Association of British Clinical Diabetologists, October 2005 (available on Diabetes UK and ABCD websites)
4. Guidelines for the appointment of General Practitioners with Special Interests in the Delivery of Clinical Services. Diabetes. Department of Health, September 2003.
5. Recommendations for the provision of services in primary care for people with diabetes. Diabetes UK, 2005
6. Recommendations for the Structure of Specialist Diabetes Services. British Diabetic Association, 1999
7. Training Curriculum for Endocrinology and Diabetes Mellitus. Joint Committee for Higher Medical Training (www.jchmt.org.uk)
8. Endocrinology and Diabetes Medical Manpower Survey 2005. Diabetes UK/Royal College of Physicians (available from Diabetes UK)
9. Diabetes and the quality and outcomes framework. Kenny C, BMJ, 2005; 331:1097-8

ABCD News

ABCD-Diabetes UK Survey

The ABCD-Diabetes UK survey of specialist services is under way and it is essential that we collect as much data as possible. We need to have all specialists' data completed on-line by the end of September. It is intended to publish the results in October and we do need input from every hospital in the country. We shall have to give the government accurate figures, if it is going to be persuaded that its present policy should be changed.

2006 ABCD Sanofi-Aventis Clinical Audit Award

The 2006 Sanofi-Aventis Clinical Audit award was offered in the field of Coronary heart Disease. It has been awarded to a consortium of Welwyn, Northampton, Portsmouth, Norwich and Glasgow, to study hyperglycaemia in Acute Coronary Syndrome. Well done to all those concerned.

Increase in membership subscription

It has been agreed that after 10 years unchanged, the membership fee will be increased to £50 per year. Our increasing clinical and political activity does have financial consequences and it is hoped that everyone will agree with this change.

CONTROVERSY

Bring back the four-letter word

Jeremy Bending, Eastbourne General Hospital

When I was a house physician I had an ebullient senior registrar who made a point of correcting my language. My ward round presentation starting with: ‘This pleasant 56 year-old lady . . .’ was met with the riposte: ‘How do you know she’s pleasant, you’re not married to her!’ He had a point, although I am not sure how many wives he’s had in the intervening years. Always interested in words, it ensured that ever since I have taken care about how I use words in medicine in particular; something that I try to pass on to those I now train myself. The early challenge I received also taught me to be careful about not making value judgements about patients who come under my care, especially if they are seriously ill.

The abstract of a recent paper in the BMJ¹ brought me up with a start: ‘Treatment with angiotensin receptor blockers was not associated with a significantly increased risk of myocardial infarction . . . our findings may alleviate recent concerns over the safety of this class of medications.’ That’s all right then, particularly since I’m swallowing one myself. But what’s wrong with using the word ‘drug’ these days? The word seems to have gone out of favour. ‘The Drug and Therapeutics Bulletin’ has not changed its name (yet) but the Committee on Safety of Medicines is treading a politically correct fine line. If the registrar or SHO dictates ‘medication’, my secretary has instructions to type the four-letter word ‘drug’. And I can’t help squirming in Grand Rounds when junior and not so junior

colleagues repeat the line about patients being ‘on’ drugs, rather than ‘taking them’.

Since we’re on the subject, the four-letter word ‘died’ is another example. I was met this morning by my house physician (sorry, FY1) with the news that Mr. Sanderson (who had been expected to die) had ‘passed away’ in the night. While that might (just) have been a helpful statement for the nurses to make to his wife, I am not sure it is appropriate talk between professionals. We all know that language is constantly evolving, a process influenced by cultural and national factors, among other things. I also blame the word processor. The worst howler I have come across recently involving the latter was in a letter from a senior hospital manager in reply to a complaint from a grieving widow. In the first paragraph he expressed his ‘sincere condolences for your sad loss’ and in the fifth paragraph ‘please convey my best wishes to your husband for a speedy recovery.’ But I digress: the point is that electronic words do not necessarily make for clarity or precision in writing. In my experience the word processor often encourages circumlocution and the use of lengthy words, where a four-letter one would have sufficed. I wonder whether the Editor of the ABCD Newsletter agrees. Submit.

Reference

1 McDonald MA, Simpson SH, Ezekowitz JA, Gyenes G, Tsuyuki RT. Angiotensin receptor blockers and risk of myocardial infarction: systematic review. *BMJ* 2005;331:873-6

Euphemisms are usually just plain silly and a sop to our politically correct society. I also worked with the ebullient senior registrar described and concur fully with his views. Polysyllabic words are fine though, because they make us sound so smart! Ed.

SUMMARY OF THE SPRING 2006 MEETING OF ABCD

Glasgow Crowne Plaza, 5/6 April 2006

At the Spring Meeting of the Association of British Clinical Diabetologists, Richard Greenwood retired as Chairman and Ken Shaw was elected to replace him. Delegates were updated on the fast-growing activities of the Association, especially important at the present time of rapid change in diabetes care services. As usual, the meeting combined state-of-the-art clinical lectures, posters, informed discussions and a lively debate.

THE ABCD LECTURE

Trial by fire: the history and development of clinical trials
Allan Gaw, Director of Clinical Trials Unit, Glasgow Royal Infirmary
The earliest proper scientific trial was probably the successful study of the prevention of scurvy by James Lind in 1747. Benjamin Franklin was the first to introduce placebo-controlled trials when he investigated “mesmerism” in 1794.

Abuses of the consent process have largely shaped modern legislation on the subject. The greatest impact was probably from the “Doctors’ Trial” at Nuremberg in 1947, when 23 Nazi doctors were indicted for numerous inhuman practices. The trial led to the Nuremberg Code, ten standards for medical research, including informed consent. As a result of these and similar abuses, the Declaration of Helsinki was issued by the World Medical Association in 1964, with the opening statement that “the health of my patients will be my first consideration”. The system of Good Clinical Practice (GCP) was established in 1984 and the implementation of this is regulated by the EU Directives on Clinical Trials. Every aspect of clinical trials is covered by these regulations. Methods of consent, involvement of various committees and the system of authorisation have all been changed recently. All but the largest

research establishments struggle to implement the new rules, which are likely to cost the pharmaceutical industry an additional 10 – 15% on their total UK research expenditure of c.£8 billion. It is argued that the new regime is too cumbersome for academic research.

THE ABCD DEBATE

“This house believes that statins should be routinely prescribed in adults with type 1 diabetes”

Proposing the motion, Professor Paul Durrington (Professor of Medicine, University of Manchester)

Opposing the motion, Dr John McKnight (Consultant Physician, Western General Hospital, Edinburgh)

OTHER PRESENTATIONS

- Cerebrovascular disease and diabetes – from epidemiology to acute care: *Dr Matthew Walters, Senior Lecturer, University of Glasgow*
- A critical review of current and future educational models for diabetes: *Dr Wendy Gatling, Consultant Physician, Poole General Hospital*
- Current and future management of diabetic renal failure: *Dr Margaret McMillan, Consultant Nephrologist, Western Infirmary, Glasgow*
- Managing the endocrinology of obesity – from the adipocyte to the brain: *Dr Nick Finan, Clinical Director, Addenbrooke’s Hospital, University of Cambridge*

See also the July/August issue of *Practical Diabetes International* for a more detailed report and the September issue for the posters presented.



Chairman's Report

Taking over the Chairmanship from Richard Greenwood is not an easy task. During his stewardship ABCD has become firmly established as a respected and powerful professional body representing UK consultant diabetologists and SpRs training in the speciality. Although from its inception we never doubted the need for ABCD we have recognised that the way ahead would have its difficulties and challenges. Richard has steered us adroitly to our present strong position and for that we are indebted. It was a privilege and pleasure to provide a few words of appreciation at the East Anglian Association for the Study of Endocrinology (EASE) to mark his retirement. Richard – we wish you well for the years ahead but I am grateful you will still be contributing to ABCD for a while yet.

These are indeed challenging times and we all have uncertainties concerning the future role of Consultant Physicians in Diabetes and Endocrinology. Much of what we have previously cherished seems to be progressively threatened with the relentless shift to Care in the Community. A recent commentary from our Royal College, entitled "Making The Best Use of Doctors skills – A Balanced Partnership" underlines how far we have gone in this direction. The College no longer envisages the terms primary and secondary care, and describes the terms "generalists" and "specialists", but this is too simplistic and we need better understanding of what these terms mean and how they are implemented. Sadly, ABCD continues to be made aware of hospital-based diabetes services struggling to survive, lacking current investment and losing resources to the community (I believe you can only sell the "family silver" once). The current ABCD-DUK Survey of Specialist Diabetes Services 2006 will provide information of immense importance to the future provision of specialist diabetes care. In the meantime we are keen to learn of positive service developments where they have occurred, for at present such knowledge is scarce.

The Spring Meeting in Glasgow was an excellent occasion. Our secretary, Peter Winocour, arranged a first-class programme of high educational content. His energy and drive is commendable and I am delighted he continues in this role. The AGM was also held at Glasgow. I am pleased that all Committee Members were able to be re-elected for a further term of office. Standing down as Treasurer it was also good to leave the Association's finances in a strong position, particularly with seven Corporate Sponsors now signed up for the next three years, and a further three companies close to commitment as well. All the best to Chris Walton as the new Treasurer. We are very grateful to Sanofi-Aventis for providing further substantial funding for the Annual ABCD National Audit Programme. Mike Sampson presented an impressive report on the first audit of UK Inpatient Diabetes Services. We look forward to the publication, as its key messages will provide crucial evidence supporting the need for dedicated diabetes support in Acute Trusts.

One important responsibility undertaken by ABCD is that of expert Consultee advice to NICE, and it is evident that the opinion of ABCD is taken seriously. The present consideration of Inhaled Insulin has required major input, and we are very grateful to Tony Barnett and Stephanie Amiel for serving as our

expert advisors. It is quite probable that ABCD will be asked to provide the audit process for evaluating the selective usage of Inhaled Insulin, once the guidance has been clarified.

Another significant developing role of ABCD is the publication of Clinical Guidelines and position statements concerning various aspects of diabetes care. Thanks to Anne Kilvert and Mark Savage for their paper on the "Management of Hyperglycaemic Emergencies in Adults" published in the June 2006 issue of Practical Diabetes International. Congratulations also to Peter Daggett as the first ABCD representative on the PDI Editorial Board.

Lastly, I am pleased to confirm we have formally concluded an agreement with Elise Harvey and Gusto Events to provide administrative support for the next three years. Elise will be responsible for organisation of meetings and mail shots as well as managing the membership database. Finally, thanks to Jeremy Bending for his years of valued service as Membership Secretary.

Ken Shaw, 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 £50.00. 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