

ABCD

Newsletter

The Official Bulletin of the Association of British Clinical Diabetologists

Editor of ABCD Newsletter

Dr P Daggett FRCP

Consultant Physician
Staffordshire General Hospital
Western Road
Stafford ST16 3SA
Tel: 01785 257731
Fax: 01785 230538
Email: peter.daggett@msgh-tr.wmids.nhs.uk



Committee Members of ABCD

Dr A L T Blair FRCP

Consultant Physician
Belfast City Hospital
Lisburn Road
Belfast BT9 7AB
Tel: 023 8283 3578

Professor B M Frier FRCP

Consultant Physician
Royal Infirmary of Edinburgh
Lauriston Place
Edinburgh EH39 9YW
Tel: 0131 5361000

Dr I Gallen FRCP

Consultant Physician
Wycombe Hospital
Queen Alexandra Road
High Wycombe
Buckinghamshire HP11 2TT
Tel: 01494 526161
Bleep: 6589
Mobile: 07958456551

Dr C Hardisty FRCP

Consultant Physician
Northern General Hospital
Herries Road
Sheffield S5 7AU
Tel: 0114 2434343

Dr E R Higgs FRCP

Consultant Physician
Royal United Hospital
Coombe Park
Bath BA1 3NG

Dr J A Kilvert FRCP

Consultant Physician
Diabetes Centre
Northampton General
Hospital, Billing Road
Cliftonville
Northampton NN1 5BD

Dr I G Lewin FRCP

Consultant Physician
North Devonshire District
General Hospital, Raleigh Park
Barnstable EX31 4JB
Tel: 01271 322577

Dr S Olczak FRCP

Consultant Physician
Pilgrim Hospital, Sibsey Road
Boston, Lincs PE21 9QS
Tel: 01205 364801
Direct line: 01205 442099

Dr C Walton FRCP

Consultant Physician
Diabetes Centre
Hull Royal Infirmary
Anlaby Road, Hull
North Humberside

PUBLISHERS

John Wiley & Sons Ltd
The Atrium, Southern Gate
CHICHESTER PO19 8SQ
Tel: 01243 779777
© 2003 ABCD

Chairman of ABCD

Dr R H Greenwood FRCP

Chairman ABCD
Consultant Physician
Norfolk and Norwich University
Hospital
Elsie Bertram Diabetes Centre
Level 3, Outpatients East
Colney Lane
Norwich NR4 7UY
Tel: 01603 286769
Fax: 01603 287320
Email: richard.greenwood@norfolk-norwich.thenhs.com



Hon. Treasurer

Professor K Shaw MA MD FRCP

Consultant Physician
Queen Alexandra Hospital
Southwick Hill Road
Cosham
Portsmouth PO6 3LY
Tel: 023 9228 6044
Fax: 023 9228 6054
Email: ken.shaw@qmail01.porthosp.swest.nhs.uk



Hon. Secretary

Dr P Winocour MD FRCP

Consultant Physician
Queen Elizabeth II Hospital
Howlands
Welwyn Garden City
Herts, AL7 4HQ
Tel: 01707 328111
Fax: 01438 716102
Email: pwinocourabcd@hotmail.com



ABCD Membership Co-ordinator

Dr J Bending FRCP

Consultant Physician
Eastbourne District General
Hospital
Kings Drive
Eastbourne
East Sussex BN21 2UD
Tel: 01323 417400



ABCD Website Coordinator

Dr R E Ryder FRCP

Consultant Physician
City Hospital NHS Trust
Dudley Road
Winson Green
Birmingham B18 7QH
Tel: 0121 5074474
Fax: 0121 507 4591
Email: bob.ryder@cityhospbham.wmids.nhs.uk



ABCD Administrative Office

33 Newman Street,
London W1T 1PY
Tel: 020 7462 5660

EDITORIAL

The Diabetes NSF at last

Peter Daggett
Editor, ABCD Newsletter

After much delay, we have the Diabetes NSF. As many of us expected, the funding is inadequate and it will be difficult to implement fully in the specialist sector. Our colleagues in general practice, who are being asked to carry the main burden of diabetes care, will also find life difficult. The Government wants something for nothing. What it will probably get is numbers from diabetes registers, but little or no improvement in the health of people with diabetes.

The recommendations of the NSF were signalled in the standards already published. Some of these are sensible, such as the plan to reduce the incidence and improve the management of diabetic emergencies. Others are theoretical, such as "empowerment of people with diabetes". We applaud the campaign to reduce the incidence of type 2 diabetes, but this is going to be a long haul. To achieve dietary change across the whole population will take maybe 50 years, but certainly we should make a start now. Identifying people at an early stage of diabetes is certainly worthwhile, but first the ADA, WHO and Diabetes UK will have to decide what diabetes actually is and how to test for it.

The most important sections of the NSF relate to clinical care of adults and children with diabetes. There is much to be done to improve all aspects of care, but we come back to the matter of resources. If a diabetic needs to see a diabetes professional on admission to hospital, which activity will the staff drop in order to do that? Of course, the answer is to appoint more specialist nurses in hospitals, but that will cost many thousands of pounds a year.

In general practice, it will be necessary for diabetes specialists to go on training courses. Who will do their work while they are away? The Government assumes that the professionalism of all involved will cause them to work harder. Ultimately, that will cause burnout and new staff will have to be found and trained. The NSF may be no more than a quick fix, in order to provide numbers that will be useful to politicians. What we need is a long-term plan, with adequate funding to allow us to do the best for our patients. It's a shame that after such a long gestation, the fetus has been born deformed.

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

INSIDE

Editorial: The Diabetes NSF at last	1
General Practitioners with a Special Interest in Diabetes: a Policy Statement from ABCD	2
NSF for Diabetes: the ABCD Response	3
Chairman's Report	4
News Round-up	4
Spring 2003 ABCD Conference (Notice)	4
Autumn 2002 ABCD Conference (Report)	5
ABCD Website (Notice)	5
Controversy: Why do people ask questions at meetings?	6
ABCD Membership Application Form	6

General Practitioners with a Special Interest in Diabetes

A policy statement from ABCD

INTRODUCTION

The burden of diabetes is increasing remorselessly and diabetes services are experiencing progressive difficulty in dealing with the clinical workload whilst delivering an acceptable standard of care. This has prompted the exploration of new models of care, amongst which is the GP with a Special Interest in Diabetes (GPSI).

Although historically much UK diabetes care has been delivered by hospitals, there is a long tradition of GP involvement in specialist diabetes care. Many hospital clinics utilise the services of skilled GP Clinical Assistants or Hospital Practitioners. The key GP role in delivering diabetes care has led over the years to innovative integrated care schemes such as Shared Care and GP Diabetic Mini-Clinics.

The enhanced GP role is in line with the government's desire to develop a primary care-led NHS. ABCD strongly supports it but believes that a proper training and accreditation programme is essential to avoid the evolution of two different standards of care. Furthermore, ABCD believes that the GPSI initiative will only succeed if there is a close and harmonious relationship between primary and secondary care, with a clear understanding and agreement of roles and responsibilities.

BACKGROUND

Diabetes is a major cause of acute and chronic morbidity and mortality, reducing life expectancy in all age groups. Disabling complications such as retinopathy, nephropathy and peripheral vascular disease incur high health care and socio-economic costs. Recent evidence from large-scale trials such as DCCT, UKPDS, HOPE and HPS shows that improved metabolic control will prevent or delay many of these complications. There is convincing evidence of significant clinical and quality of life benefits from high-quality diabetes care.

A recent Diabetes UK Survey of Diabetes Care in General Practice in the UK revealed alarming deficiencies in resources and health care expertise. A parallel survey of secondary care diabetes services carried out by ABCD has shown a similar variation in resources. As a result of these and other considerations a number of innovative models of diabetes care are being examined. These include the General Practitioner with a Special Interest in Diabetes (GPSI).

ABCD believes that these new approaches can only be effective if they are actively supported by local Consultant Diabetologists. This paper sets out ABCD's views on the minimum training requirement, competency and relevant CPD for GPSIs. ABCD feels that it is vital that training and performance standards are defined at the outset. It would be unacceptable if patients were to be offered a lesser standard of care as a result of an 'innovation' untested in practice.

GPSI's - KEY QUESTIONS TO BE ADDRESSED

- What will be the precise role of the GPSI?
- What training will the GPSI require to become competent?
- What tests of competency will be necessary?
- Who will provide the training and assessment of competency?
- How will GPSIs relate to local secondary care services?
- What will be the arrangements for appraisal and revalidation?

THE ROLE OF THE GPSI IN DIABETES

With adequate training and competency the GPSI could take over the care of a major proportion of patients with diabetes. Patient groups for whom specialist service care may be generally more appropriate include:

- 1) Children and adolescents with Type 1 diabetes.
- 2) Pregnant patients with diabetes.
- 3) 'Brittle' insulin-treated patients.
- 4) Patients with severe complications, eg retinopathy, nephropathy or foot problems.
- 5) Patients who express a preference for secondary care.

The care of many patients could be 'shared' between the primary and secondary sectors but this would require effective co-ordination and communication. Once an adequate level of competency has been achieved it is probable that GPSIs will receive direct referrals from colleagues in primary care. It is very important that the above criteria are applied to these.

TRAINING AND COMPETENCY

Initially it is likely that most General Practitioners (GPs) intending to become GPSIs will have previous experience of working in hospital diabetes clinics. With these, evidence of at least 12 months continuous employment (minimum one session per week) in a consultant-supervised clinic, plus confirmation of competency by the local consultant, might be considered a sufficient guarantee of adequate training. For GPs without this background experience, a requirement to work in a consultant-supervised clinic for 12 months (minimum one session per week) would not be unreasonable. There could be special dispensation for GPs who have worked as registrars/specialist registrars in a hospital-based diabetes service, although this might have to be time-limited.

Competency could be assessed by an 'exit' test, eg a diabetes knowledge MCQ, leading to the award of a Diploma. This would probably not be achievable without substantial additional central funding. Training is available through 'Warwick' and other similar courses. Supplementary training should be available in local diabetes clinics. Training must cover all relevant areas including up-to-date knowledge of therapies, control targets and the detection and management of complications. Communication skills are especially important, but these are generally well developed in primary care.

The relationship of GPSIs to local secondary care services is crucial. There will need to be clear guidelines and definitions of respective responsibilities, care pathways and referral policies, requiring close co-operation between primary and secondary care. Clearly defined arrangements for the regular appraisal and assessment of competency of GPSIs should involve a requirement for evidence of adequate and appropriate CME to enable them to keep up-to-date with clinical developments. Local diabetes consultants could help with this. Eventually appraisal arrangements might become reciprocal.

There would be much merit in a continuing involvement of the GPSI in the local diabetic clinic, eg by working with the consultant for one session a week. This would have educational benefits and provide an important communication link between primary and secondary care. Other important issues for both primary and

continued on page 3

continued from page 2

secondary care are district diabetes registers, audit and clinical governance. Again, local diabetes consultants would be able to support these activities.

GENERAL POINTS

- The development of GPSIs is an exciting opportunity to improve the standard of primary care of diabetes and relieve the pressure on local specialist care services, thus improving patient care in both sectors.
- GPSIs must be adequately rewarded and provided with adequate resources to function effectively. These will include appropriate facilities, adequate support from practice nurses experienced in diabetes care and access to support services such as retinal photography and specialist podiatry.
- GPSIs will not be consultants specialising in diabetes. The consultant diabetologist undergoes a rigorous five year specialist training programme culminating in the award of a CCST. Most consultants are also trained specialists in general medicine which is very appropriate for the management of complicated patients with multi-system problems. Consultants have access to acute medical beds which enables them to provide specialist care for

patients with acute diabetes complications such as ketoacidosis. They also work closely with other specialities such as vascular surgery and orthopaedics.

- Diabetes, because of its chronicity, complexity and necessity for patient education and motivation, is more holistic than other medical specialities. There is increasing emphasis on patient empowerment and it is very important to ensure that there is active patient participation and support for any new model of care. The issue of informed patient choice must be recognised. If the patient prefers a primary or secondary care environment, this preference should be met wherever possible.
- The successful introduction of GPSIs will require substantial support from secondary care. Time for this must be built into consultant job plans and adequate resources provided. At the same time, resources to support secondary care diabetes services must be maintained. There is evidence that improvement in primary care of diabetes leads to an increase in specialist referrals. In this eventuality, additional resources must be provided.

Richard Greenwood

Chairman, on behalf of ABCD

Editor's note: A full version of this abbreviated paper can be seen on the ABCD website

National Service Framework for Diabetes: the ABCD Response

Diabetes is a common chronic medical condition, a major cause of ill health and reduced life expectancy. Diabetes-related problems can be substantially reduced by good quality care. ABCD's primary objective is to encourage improvement in diabetes management in both secondary and primary care. The prevalence of diabetes is increasing remorselessly and the current provision of care is extremely variable. ABCD welcomes the NSF as a major quality initiative and is encouraged by the following stated objectives:

- Expanding and accelerating screening and treatment of diabetic eye complications and providing supporting funding.
- Development of practice-based registers.
- Development of protocols/guidelines with associated audit.
- Establishment of Local Diabetes Networks.
- Development of the role of the General Practitioner with a Special Interest in Diabetes.
- Extending prescribing by nurses, pharmacists and allied healthcare professionals.
- Encouraging the empowerment of patients.
- Tackling obesity, probably the most important single cause of the current diabetes 'epidemic'.
- Providing funding within the General Medical Services baseline allocations (although it seems this will not be 'ring-fenced').

However, ABCD has a number of concerns about the NSF recommendations:

'Shift of focus of diabetes management from secondary to primary care': Most districts are well served by specialist diabetes departments led by highly trained and committed consultants. Diabetes care in general practice is much less developed and few GPs have the training and expertise to enable them to deliver up-to-date evidence-based care and manage complex diabetes-related problems. The needed long-term educational programme will take some years to achieve results. In the meantime, the specialist team should continue to be the focus of the local diabetes service.

Lack of emphasis on integrated care: ABCD is disappointed that there is not more emphasis on the development of

comprehensive computer-based District Diabetes Registers. These would greatly facilitate the monitoring and audit of care. Effective integration of care may be more difficult to achieve with isolated practice-based registers.

Lack of emphasis on serious complications: The immediate clinical priorities (other than retinopathy) identified in the NSF are improved management of newly diagnosed patients and those with poor control. ABCD is disappointed that more emphasis has not been given to serious and treatable complications such as nephropathy and foot problems.

Unrealistic performance indicators: Some of the performance indicators referred to in the NSF are unrealistic. It would be more helpful to measure progress towards agreed targets than to compare unlike districts/practices.

Inadequate funding of outreach clinics: Unless the recommended community outreach clinics are adequately supported and properly equipped they may not represent a cost-effective use of a scarce specialist resource.

Apart from these reservations ABCD broadly welcomes the NSF. Diabetes Specialists are well placed to provide expert knowledge and leadership for the proposed Diabetes Networks. However, the current provision of diabetes consultants in England is inadequate. ABCD is encouraged by the stated intention of increasing consultant numbers 'by well over 50% over the next 8 years' but this will only produce approximately one consultant per 70,000, well short of the agreed ideal of one per 50,000. In order to achieve this there would need to be a large and immediate increase in trainee numbers and there is little evidence of this happening. This issue needs to be addressed urgently otherwise there may be insufficient specialists to provide the educational and expert resource to encourage diabetes expertise in primary care.

Dr Richard Greenwood, Chairman
Professor Ken Shaw, Treasurer
Dr Peter Winocour, Secretary

Editor's note: A full version of this abbreviated statement appears on the ABCD website



Chairman's Report

At long last the NSF has appeared, 18 months later than planned. This 'limbo' period has been a deeply unsettling time for diabetes services. Whilst welcoming the increased emphasis on diabetes (especially for PCTs and NHS Managers), all those involved in diabetes care must be apprehensive about the resource implications of having to meet the large number of service (eg retinopathy screening) and performance targets (eg glycaemic control, BP etc) set out in the Delivery Strategy and the myriad of linked supporting papers and websites. Clearly, much of the immediate impact of the NSF will predominantly affect primary care and PCTs but there is little acknowledgement of the "fall out" effect on secondary care. This, taken together with the tough standards for acute hospital management of diabetes emergencies and the imperative to develop "patient empowerment", is going to result in major additional pressure on specialist services. Although there will be some funding for retinopathy screening and there is talk about the provision of additional funding for PCTs within the General Medical Services baseline allocations, there will be no "ring-fencing" of resources to support the NSF and we know many PCTs are already crippled by historic debts.

What can be done to help the situation? One initiative is the development of the "GP with a Special Interest in Diabetes"

(GPSI). ABCD welcomes this scheme providing there are adequate safeguards concerning training, competence and links to local specialist care. The views of the ABCD Committee are set out in a paper in this issue of the Newsletter.

Despite these uncertainties and threats, ABCD continues to thrive. Membership is growing and we are now recognised as a significant professional representative organisation. We have been asked to contribute to many important national initiatives, including the NSF and NICE Guidance. The Autumn 2002 Meeting was very successful (and for the first time oversubscribed). A report on the proceedings is included in the Newsletter. We will hold future meetings in larger hotels or conference centres whilst ensuring that we maintain the intimate relaxed atmosphere that has characterised our previous meetings and contributed to their success. ABCD's progress has been facilitated by the establishment of an administrative office in London (see contact details on front cover). Further development of the Association will require substantial growth in funding and infrastructure. The Committee and Trustees are currently considering how to achieve this. We have had and anticipate continuing strong support from the pharmaceutical industry and we are grateful for this. I look forward to seeing you in Cardiff in May.

Richard Greenwood
Chairman, ABCD

NEWS ROUND-UP

Consultant diabetologist appointments during 2002

During the year, 49 posts were advertised and AACs held. Nineteen were because of retirements or long term vacancies, but 27 were new jobs and it is pleasing to note that the importance of our specialty is being recognized (insufficient data were available on three jobs). A breakdown appears below.

	Held	Retirement	Long term vacancy	New post	Not appointed
Diabetes	5	1	0	4	2
Diabetes/Endocrin.	44	9	9	3	6
Total	49	10	9	27	8

It is worrying that 8 out of 49 (16%) posts were left unfilled. It suggests that there are insufficient trainees. If you have a post "on the stocks" please let the Editor of the Newsletter know as soon as possible, so that it can be publicized in these pages before it is advertised formally (see contact address on front cover).

The Editor is grateful to the Royal College of Physicians of London for providing the raw data on which this analysis is based.

New post at Barts and the London NHS Trust

Applications are invited from motivated and enthusiastic individuals for a new post for a Consultant Physician in Diabetes/Metabolism and General Medicine based at the Royal London Hospital. The recently expanded Diabetes and Metabolism service provides secondary care diabetes services for Tower Hamlets and tertiary care obesity and lipids services for East London. The Academic Department of Diabetes and Metabolism has ongoing diabetes and obesity-related research projects.

The post-holder will join four Consultants in Diabetes and metabolism and six Diabetes Specialist Nurses on the Whitechapel site and three Consultants on the Barts site. He/she will be expected to take a lead in delivering high quality services to Tower Hamlet patients. There will be a shared commitment to the acute GM in-patient service for six months of the year, and to teaching medical students from Barts and the London Queen Mary Medical College, plus protected time to carry out service development and academic activities. If you are interested, please contact Dr Tahseen Chowdhury on 020 7377 7000 ext 4384 or e-mail tahseen.chowdhury@bartsandthelondon.nhs.uk

Audit presentations at future ABCD Meetings

It is planned to include a session comprising two or three brief audit presentations (15 minutes plus 5 minutes discussion) at the November 2003 and subsequent ABCD meetings. ABCD is seeking submission of completed projects for consideration. Please send a 200 word abstract to Peter Winocour, Hon Secretary, preferably by e-mail (see front cover for contact details).

Jeremy Bending is new ABCD Membership Co-ordinator

Jeremy Bending (Eastbourne) is the new Membership Co-ordinator for ABCD. Membership Application Forms and enquiries about membership should now be directed to him. If you are interested in joining the Association, or know anyone else who might be, Dr Bending will be very pleased to hear from you. Please write to: Dr Jeremy Bending, District Diabetes Centre, Eastbourne District General Hospital, Kings Drive, Eastbourne, East Sussex BN21 4UD.

FORTHCOMING ABCD MEETING

Thursday/Friday, 8/9 May 2003 – ABCD Spring Meeting
Cardiff Thistle Hotel, Cardiff

AGM - Debate: Glitazones represent a major advance in the treatment of type 2 diabetes (*For Prof Tony Barnett; Opposing Prof Edwin Gale*)

Plus state-of-the-art lectures on: The implications of the EU working time directive on the future of acute medicine (*Dr Hugh Mather*); Treating to target in type 2 diabetes (*Prof Hannelle Yki-Jarvinen*); New approaches to the treatment of erectile dysfunction in diabetes (*Dr David Price*); Surgical treatment of obesity (*Mr Steve Pollard*); Pitfalls in the diagnosis and treatment of phaeochromocytoma (*Dr Pierre Bouloux*); Recent advances in hypolipidaemic therapy (*Dr Alan Rees*).

Hotel details: Cardiff Thistle Hotel, Park Place, Cardiff CF10 3UD. Reception: 0870 333 9157. Fax: 0870 333 9257. E-mail: cardiff@thistle.co.uk. Website: www.thistlehotels.com/cardiff

Registration/programme details: Dr Peter Winocour, Hon Secretary ABCD (see front cover for contact details)

Highlights of the ABCD Autumn 2002 Meeting

Euston Thistle Hotel, London NW1, Friday, 22 November 2002



A record 85 delegates attended the Conference, which was supported by Eli Lilly, Fournier, Servier and Takeda.

DEBATE: TYPE 2 DIABETES (T2DM) IS PREVENTABLE BY LIFESTYLE MEASURES

Dr Jonathan Pinkney (University Hospital, Aintree) cited as first evidence in support of the motion the US Behavioural Risk Factor Surveillance Survey, comparative studies of the Arizona and Mexican Pima Indians (figure) and a study of urbanised DM Aborigines whose metabolisms reverted to near-normal after they returned to a traditional bush lifestyle. The most important evidence was from the Malmo Study, Da Qing, the American DPP and the Finnish DPS. The resources involved might be considerable but "proof of concept" had been demonstrated and the motion should be supported.

Dr Stephen Robinson (St Mary's Hospital, Paddington, London), opposing, said Dr Pinkney had demonstrated delaying but not prevention of T2DM. Lifestyle intervention after DM developed was in any case too late. The UKPDS had concluded that the point at which DM patients still had normal beta cell function was 12-14 years prior to diagnosis. The costs of lifestyle intervention were likely to be massive and drugs might be more cost-effective. And should it be primarily the responsibility of doctors to change people's lifestyle?

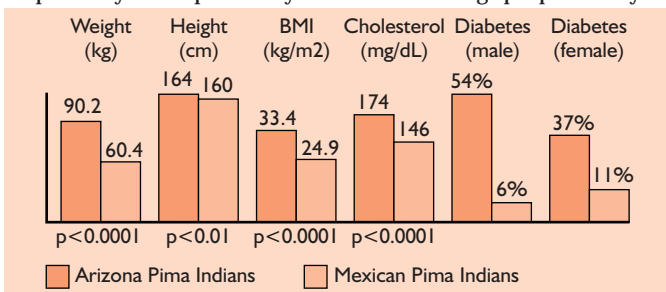


Figure. Results of a study to investigate the differences between Arizona Pima Indians and Mexican Pima Indians in body mass index (BMI), cholesterol and prevalence of diabetes

Plenary discussion

Why not combine T2DM with coronary heart disease (CHD) and drugs with lifestyle measures? It was difficult to disentangle the effects of diet and physical activity. The waist/hip ratio or a simple risk stratification questionnaire could identify the same at risk population as the OGTT. A paper suggesting taxing saturated fat from the New Zealand Public Health Commission never saw the light of day. The Oxford Lifestyle Study produced no changes in IGT patients. How many people were amenable to sustained lifestyle change? Patients did not know what they were "choosing" when "choosing" to become diabetic.

We should not medicalise primary prevention but doctors could have an influence on public health initiatives - ABCD should set up a working group to consider the role of a district consultant physician. Why were people living longer, if we were all getting fatter and doing less exercise? Answer: we would all spend longer being ill. A lifestyle intervention was needed to delay the onset of DM and ensure that people died of something else first - for example, riding a bike in Central London!

The debate chairman, Chris Walton, pronounced the motion carried by 41 to 33 votes.

NEW SERVICE MODELS FOR THE PROVISION OF SPECIALIST DIABETES CARE

The Community Consultant Diabetologist (CD): Dr Peter Hollins (Bradford)

This post resulted from diabetes follow-up being relocated to PC. Some GPs saw the CD as a "project facilitator", with no clinical role.

Other GPs provided Dr Hollins with a clinical base in a community outreach clinic. His most important relationship was with the community DSNs. Common problems raised at a weekly case conference were non-adherence and post-intervention rebound. There were sometimes difficulties in getting repeat prescriptions and foot and eye reviews from GPs. Other CD downsides were professional isolation, divided specialist services, duplication of effort and inefficiency. But community clinics allowed patients to see the same professionals, mean HbA1c had improved by 1% and the number of patients receiving specialist care had doubled to 4,000. Given adequate support from DSNs, specialist GPs could achieve as good glycaemic outcomes as diabetologists. In future the Consultant Diabetologist should be appointed to the district.

The Three Ages of Medical Man (Hollins)

- The Age of Innocence ("we can get the patients to do what we want")
- The Age of Realism ("we realise it is not so easy")
- The Age of Experience ("we realise it cannot be done")

The Nurse Consultant (NC): Sue Cradock (Portsmouth)

Making a difference and *The NHS Plan* discussed using nurses in better ways. A further reason for the NC was the need to retain experienced nurses in clinical practice. So far, 12 DM NCs had been appointed in England. In Portsmouth, the NC was required to make sure the implications for PC of planned hospital changes were taken aboard. Other NC-related projects included structured patient education, agreed common patient goals, intensified insulin programmes for people with T1DM, links between diabetes and mental health services, nursing practice guidelines, professional diabetes education and training certificates, the role of specialist diabetes practice nurses and a district-wide IT system.

The GP Specialist: Dr Kieran Walshe (Dromore, N. Ireland)

Dr Walshe had spent 10 years in hospital medicine and had T1DM himself. He had submitted a proposal 2/3 years ago for total PC DM care in a group of practices of 15 GPs, 22,000 patients and 650 people with diabetes. One GP in each practice acted as the diabetes lead. Dr Walshe ran a "virtual clinic" with a newly-appointed DSN twice a month. He advised her what to do about the problems, she followed them up and then care was devolved to the GPs. Dr Walshe rarely saw these patients. Common targets and IT system made it possible to audit and compare results. Guaranteed extra funding for two years of £100 per patient pa covered the cost of employing locums. The system allowed the GP Specialist to provide a clinic in practices that were not interested in DM and the DSN to follow up neglected people in nursing homes.

Plenary discussion points

- CDs should rotate six-monthly between hospital and community (Hollins)
- I don't want to lose consultant physicians but some may be in the wrong place (Cradock)
- The hospital will treat specific problems, then the patient will return to PC (Walshe)
- The ABCD proposal of formal hospital attachments for GP Specialists is good (Walshe)
- You can obtain extra DM resources under other headings, eg CHD (Cradock)

DETAILS ON YOUR ABCD WEBSITE!

www.diabetologists-abcd.org.uk



A more detailed report on the meeting appears in the March 2003 issue of *Practical Diabetes International* and can be accessed via the PDI website as well as on the ABCD website (address above), along with other interesting and useful information relating to the activities of ABCD and its members. If you have any comments or suggestions about the website, please contact the ABCD Website Officer, Bob Ryder on Tel No: 0121 507 4591 Email: bob.ryder@cityhospbham.wmids.nhs.uk

CONTROVERSY

Why do people ask questions at meetings?

Peter Daggett
 Editor, ABCD Newsletter



I have often wondered what motivates people to ask a question at a scientific meeting. You all know the scenario. A junior member of a team has given a paper, sometimes in what is a foreign language for him or her and is anxiously waiting for questions. A familiar figure strides to the microphone. He makes observations lasting 5 minutes explaining that he has in fact already done all this work himself and ends with the question “can you explain that?”. The correct answer is “no, can you?”, but the hapless presenter struggles to construct a reply. He fails and the great man returns to his seat confident that the audience will once more have been amazed by his erudition.

You will have noticed that it is always the same people who ask questions. The chairman invariably recognizes them and calls them by their first name, because they are either personal friends, or work in the same institution. In the next session, the chairman and the questioner change places and so it goes on. Regular conference goers are fed up with this coterie, but do not have the academic credentials and are too tired to object – they have been looking after patients rather than test-tubes. I submit that the only

reason these great men ask questions is to show-off. If they really want to clarify a point, why don't they seek out the presenter and ask them personally? A civilized conversation is then possible without rush and there can be a useful exchange of views. The only valid reasons for interrogating a presenter in public are if the data are clearly stolen, wildly misinterpreted, or obtained unethically. I can't remember the last time that happened.

The Europeans and Americans have learned this lesson and it is unusual at their meetings to see bullying on the scale found in the UK. Chairmen of meetings should remember how frightening it is to be a junior presenter, particularly in a foreign country. It should be their responsibility to protect speakers from the small group of chums who think it is clever to show off at meetings. They should be prepared to tell windbags to sit down and be quiet – they might even get a round of applause, as happened at a recent meeting in the USA. The meetings would run on time, people from smaller institutions would not feel intimidated at presenting their work and we might actually learn more. It's time for a “stop Professor Puff” campaign!

Editor's Note: These views are my own. I am sure that many of a more liberal mindset will disagree with me. If so, please write to the Newsletter – this column is supposed to stimulate debate.

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 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 417400

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