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ABCD Newsletter

The Official Bulletin of the Association of British Clinical Diabetologists

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The Atrium,
Southern Gate,
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Tel: 01243 779777
email: practical_diabetes@wiley.co.uk

EDITORIAL

Where have all the trainees gone?

Peter Daggett
Editor, ABCD Newsletter

I am old enough to remember Peter, Paul and Mary asking this about flowers. The answer was that they had gone for soldiers every one, but in the case of junior doctors, they seem just to have disappeared. It is now common for there to be only one or two good applicants for a "plum" consultancy and not unknown for there to be none. Twenty years ago, there were up to a dozen highly qualified people after every job and it's clear that something has gone wrong. Diabetology seems particularly badly hit and there are many unfilled posts throughout the country.

Our Chairman has asked for information from the membership about the problem, but essentially we have to ask ourselves, is there something wrong with diabetes as a career? In the seventies, such characters as Arnold Bloom and David Pyke enthused their own staff and entertained us at meetings of the BDA. It was a fun specialty and one which doctors liked because we became friends with our patients. In the mid 1980s, though, there was a generalized charisma failure and educators came to tell us we were useless. Apparently, we had all been beastly to our patients for years and the only way forward was team working. Nurses became more and more involved with the way we do our work and we welcomed this, but some tried to take over. This coincided with GPs flexing their muscles and when the BDA joined in the general antipathy towards specialists, many junior doctors decided to do something where their efforts would be more generally appreciated. This folk memory persists and has been compounded by the fact that our specialty is the only one with no practical procedures. Put simply, it has become boring. We have the additional handicap that because we don't push a tube into some part of the patient, managers can't understand what we do all day. No credit is given for thinking and in many hospitals diabetes is simply ignored.

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What can be done? First, specialist physicians should reassert their authority and make it clear to PCTs and the like that only they have the knowledge and experience to direct diabetes services. Second, we should ask colleagues in other disciplines to teach our trainees some relevant techniques. For example, SpRs in diabetes could select from learning how to use a laser, the principles of nerve conduction testing, or renal biopsy. Some specialists might raise objections (old fashioned demarcation disputes), but these should not be insuperable. It's pretty clear that the existing services can't cope with the present level of diabetic complications and the numbers will certainly increase - help should be welcomed. Third, newly appointed specialists in diabetes should be told that they can have the special equipment they need, which will depend on the skills they have acquired – gastroenterologists and cardiologists seem to have no difficulty getting what they want! Finally, we will have to do something about General Medicine. This is taking up more and more of our time and very soon ours will be one of the few specialties with the breadth of knowledge to deal with an unselected medical take. This is high stress work and the new consultant contract recognizes the fact. If Diabetologists are to become the last of the true general physicians, we might suggest to our employers that they make an acknowledgement of our importance financially – what is wrong with asking for what we deserve? We are in our present predicament because we allowed ourselves to be swept along by the "work ethic" of the past and then by a tide of political correctness. This doesn't appear to have happened to the same extent in the USA or continental Europe. Unless we do turn back the clock a little, we may find that in 10 years time, Diabetology as a hospital-based specialty ceases to exist in the UK.

ABCD SPRING 2004 MEETING

Thursday/Friday, 20/21 May 2004
Manchester Airport Marriot Hotel
Hale Road, Hale Barns, Manchester WA15 8XW

Programme
In addition to the AGM and Association Reception and Dinner, the programme will include:

The ABCD Debate
Comprehensive measurement of microalbuminuria has no place in the routine care of type 2 diabetes.
(Proposer: Dr Felix Burden, Opposer: Dr James Walker)

The ABCD Lecture
Clinical excellence awards
(Sir Netar Mallick, Medical Director, Higher Merit Awards Committee)

Other Lectures
Presentation and management of male hypogonadism
(Dr Fred Wu)

Management of difficult diabetic neuropathy
(Dr Solomon Tesfaye)

Current and future management of diabetic heart disease
(Dr Clive Weston)

Managing the transitional care of adolescent diabetes
(Dr Peter Betts)

Plus
Selected clinical audits (please submit abstracts to the Hon Secretary)

CME Accreditation applied for

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

Report on a meeting on the introduction of the IFCC reference method for the standardisation of HbA1c Measurement

Dolphin Square Hotel, London, 1 July 2003
Chairman: Sue Roberts, National Clinical Director for Diabetes

The measurement and interpretation of HbA1c in the blood samples of people with diabetes is the currency of all our daily work. The current basis of standardisation of measurement of HbA1c is the Goldstein HPLC method. A number of other molecules have the same peak as HbA1c in this method, therefore it actually measures a group of chemicals. Consequently we are not measuring HbA1c accurately. New more robust methodology has been developed, which has less interference and therefore measures HbA1c more accurately. There are, however, concerns about the implementation of the new assay and any suggestion of change made to this vital tool on which we rely is likely to be greeted with some anxiety. Dr Sue Roberts, the National Clinical Director for Diabetes, invited a group of interested parties, representing industry, biochemists, diabetologists (Diabetes UK and ABCD), patient advocates and patients, to discuss the implications for the standardisation of HbA1c measurement. We now report the data and discussion presented at the meeting.

IFCC (International Federation of Clinical Chemistry and Laboratory Medicine) Reference System for HbA1c

HbA1c is the stable glucose adduct to the N-terminal group of the b-chain of HbA. As there was no internationally agreed reference method, an IFCC Working Group on HbA1c Standardization was set up to develop a robust reference method that could be adopted internationally. In the first step

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haemoglobin is cleaved into peptides by the enzyme endoproteinase Glu-C, and in the second step the glycated and non-glycated N-terminal hexapeptides of the b-chain obtained are separated and quantified by HPLC and electrospray ionisation mass spectrometry or in a two-dimensional approach using HPLC and capillary electrophoresis with UV-detection. Both principles give identical results. HbA1c is measured as ratio between the glycated and non-glycated hexapeptides. The method is therefore scientifically more valid than the Goldstein HPLC method and is also compliant with the European directive to be applied by 7 December 2003, when all biochemical tests must be calibrated to the highest order.

An international network of reference laboratories from Europe, Japan and the USA has been established to ensure that continued analytical quality is maintained. The inter-comparison studies of the network showed excellent results with intra-laboratory CVs of 0.5 - 2% and inter-laboratory CVs of 1.4 - 2.3%. The IFCC has investigated and reported on the implication of transfer from the method of measurement of HbA1c using the DCCT-aligned method (also known as NGSP) to the IFCC method (r=0.9992-0.9996). There is also good correlation between the IFCC assay and other assays used in European (Mono-3), Japanese (JDS) or Australian studies.

The higher specificity of the IFCC method means that cross-reactivity is reduced and so the results are lower than those generated with most of the commercial methods that currently are calibrated with unspecific designated comparison methods. In particular, the IFCC methodology reports HbA1c values that are approximately 2% lower than DCCT-aligned results, providing a normal range of approximately 3 - 4%, a target value of 5% and an action value of 6%. It is possible to make a master equation to convert IFCC (x) to DCCT (y) values (y = 0.9148x + 2.125). The validity of the new method is confirmed by the observation that when mean blood glucose regresses to zero, the IFCC HbA1c is also zero, whereas with the DCCT-aligned method it is 2%.

Manufacturers' Perspective

Currently in the UK there are seven manufacturers of HbA1c measurement machines, the most common being made by Menarini (four types), Biorad, Bayer and Roche. Industry has been working closely with both the NGSP and IFCC to develop assays and most manufacturers will be able to offer calibrators for both the DCCT and IFCC assays by September 2003. Currently 95% of manufacturers' products report DCCT-aligned results. The European Directive on Laboratory Methods is being implemented in order to ensure quality, reliability, clear labelling, traceability and safety. It has more implications for the manufacturers than end-users, in that the responsibility that an assay is compliant lies with the manufacturer. HbA1c is not specifically provided for but falls under the umbrella of this legislation.

Current Laboratory Position

The reliability of the results of the HbA1c assays has improved through the drive to ensure that the assays are DCCT aligned and now in the UK most centres are DCCT-aligned, with their quality being maintained through either NEQAS or WEQAS. These centres use samples from volunteers with diabetes to calibrate laboratories. The quality of alignment of UK laboratories is high. The coefficient of variation (CV) for the assay has fallen from 7.7% to a mean of 4.0% over the last 10 years, with the best laboratories achieving a CV of <2.5%. Clinical samples as well as volunteer samples have been used to verify the correlation and bias between the DCCT and IFCC assays. Further details on these methods can be found at clinchem@ukneqas.org.uk (keyword DH HbA1c talk).

Clinical Implications

Whilst a change to the IFCC reference method is required by the European Directive and is methodologically superior, there are of course important considerations for people with diabetes and their health care professionals. We need to be satisfied in advance that the new IFCC standardised methodology is clinically as well as scientifically robust and reliable and, most important, means the same as the previous HbA1c value.

The standardisation of HbA1c is crucial for individual patient care, as well as audit bench-marking of services and research. The DCCT and UKPDS long-term outcome trials have provided clinicians with evidence about the benefits of improved control. In particular the relationship between the risk of complications and hypoglycaemia is firmly established. This allows the clinician to agree with the patient on individual targets and the specific benefits accrued by any given improvement in control. The DCCT and UKPDS studies were based on the NGSP assay and there is concern that moving to a different assay will remove the direct relationship between HbA1c and clinically relevant outcomes.

Around a decade ago, there was a move from HbA_1 to HbA1c and this change was achieved without too much difficulty. Will the change to IFCC affect care? A paper published in *Diabetes Care* (Hanas R. Psychological impact of changing the scale of reported HbA(1c) results affects metabolic control. Diabetes Care 2002; 25: 2110-1) suggests that there may be grounds for concern. The effect of changing assays was studied in 49 children with type 1 diabetes. Three different assays were used during the study period. Prior to 1992 the reference range was 3.6 - 4.6%, between 1992-97 the range was 4.1 - 5.7% and post-1997 the range was 3.1 - 4.6%. The results of the assays were aligned to assess the "true" glycaemic control during the study. When the second assay with the higher normal range was introduced, glycaemic control improved for the first 2-3 years before returning to baseline, while glycaemic control deteriorated when the third assay, with the lower reference range, was implemented. Glycaemic control had not returned to baseline by the end of the study. The implication of this study is that the actual numbers do matter and the introduction of a new assay may result in poorer control.

The future

It is inevitable that there will be a change in the laboratory to IFCC standardisation but there are three possibilities for future reporting of HbA1c data: (i) we could move straight to the new IFCC lower ranges, re-educating patients and staff; (ii) both the DCCT and IFCC results could be reported concurrently, with a plan to switch over at some point in the future; (iii) we could convert IFCC values to the well-understood DCCT-aligned values. Whilst many of us will be comfortable with the last option, it might seem somewhat ridiculous in 10 years time if we are converting reports to an outdated standard aligned to an ancient study! If anyone has strong views on the matter, please let us know through ian.gallen@sbucks.nhs.uk or righ@soton.ac.uk and we will forward these on.

Ian Gallen and Richard Holt

Highlights of the ABCD Autumn 2003 ABCD Meeting

Radisson Marlborough Hotel, London WC1, 13/14 November 2003

Opening this well-attended meeting, Richard Greenwood paid tribute to Tom Delaney, who had died unexpectedly a few days previously. Mr Delaney, the Chairman of Magellan Communications, had provided valuable support to ABCD. Dr Greenwood also expressed ABCD's thanks to the companies which had supported the meeting: Eli Lilly and Company Ltd; Hemocue Ltd; Servier Laboratories Ltd; and Takeda UK Ltd.

DEBATE: THE NSF STRATEGY FOR RETINAL SCREENING WILL NOT PREVENT BLINDNESS FROM DIABETIC RETINOPATHY

Speaking for the motion: Professor Roy Taylor (Newcastle upon Tyne)

Roy Taylor drew a distinction between being in favour of effective retinal screening and supporting the Diabetes NSF strategy. Effective eye screening had to be part of the overall care of the person with diabetes. The NSF adopted a top-down approach with impossible population-based targets. This meant that decisions about what was appropriate for the District would not be made by the Consultant and specialist team, but by Primary Care Trusts (PCTs). Their abilities in this respect were uncertain. The NSF strategy had spawned a national retinal screening programme that saw itself as a free-standing entity rather than as providing one part of a coordinated system of care for patients (fig). Information on the eyes helped to determine appropriate targets for individuals with respect to blood pressure and glucose control. A further problem concerned the pressure upon GPs, fuelled by their new contract, to identify people with borderline diabetes or IGT and to overload the system with unnecessary screening. There was no clear commitment to ongoing funding of eye screening in the NSF document.

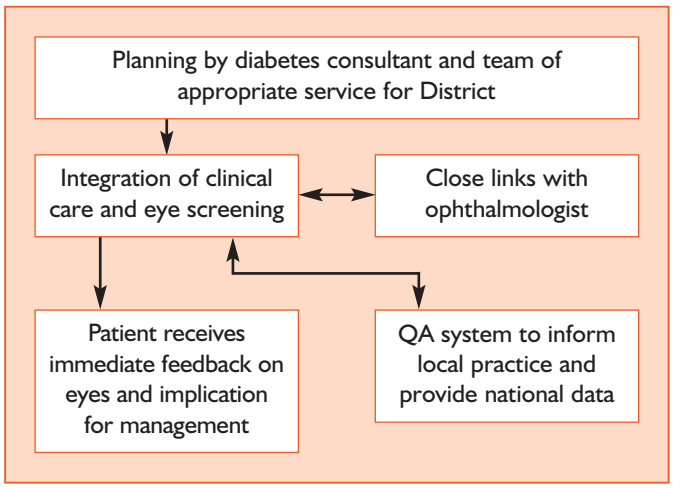

Figure. Clinically Appropriate Care
(Reproduced by permission of Roy Taylor)

Capital Funding for Screening in England
• £5 million capital is available in 2003/04
• £9.6 million in 2004/05
• £12.4 million in 2005/06
• The money will be apportioned on a fair shares basis.
• The capital will be apportioned on a population basis and will go to the NHS body that will actually spend the capital.

Table. *(Reproduced by permission of Peter Scanlon)*

Speaking against the motion: Dr Peter Scanlon (Cheltenham)

Peter Scanlon pointed out that only a small proportion of people with diabetes were being screened. In Bristol in 1994 50% of diabetic patients who were registered blind had not been screened for diabetic retinopathy. In 2000 only 38% of UK health authorities had any form of eye screening programme. The aim of the National Screening Committee (NSC) was to achieve annual population coverage to try and detect patients with retinopathy, who would then get special attention. For 2003-2006, £27 million of additional capital funding for screening had been obtained (table). There would be direct payments to GPs, which would certainly help to generate action from the PCTs. Large reductions in the prices of digital cameras had been negotiated nationally. The initiative was not "top down", bearing in mind that the work had been done by practising clinicians such as Dr Scanlon. Local leadership would certainly be necessary and members of ABCD could play a vital role.

After a lively question and plenary discussion period and a summing up by the propose and opposer, a vote was taken and Dr Ryder pronounced the motion carried by a vote of 43 to 34, a smaller margin than in the vote taken before the debate.

LECTURE: THE DIABETES NSF: WHAT IS THE ROLE OF THE CONSULTANT PHYSICIAN-DIABETOLOGIST?

Sue Roberts, National Clinical Director for Diabetes, Department of Health

Sue Roberts thought there had never been a better time to help improve the lot of people with diabetes but that it would be impossible to deliver the Diabetes NSF unless diabetes specialists were properly valued. Systematic care was seen to be capable of handling very large populations and had moved away from hospital-based specialists because of the huge variations in services and outcomes. But diabetes could surely capitalise on new DoH thinking about the importance of chronic disease management (CDM) and self-management. The latter was reflected in the NHS requirement that every patient should have a named contact, structured education and a care plan. Specialist care would have to reconfigure because within 10 years 85% of CDM would be carried out in primary care. There were already hospital-led intermediate care outreach programmes and PCT-led initiatives of Community Diabetologists and GPs with a Special Interest in Diabetes. Specialists worked very largely at the expensive end of the patient's life journey with diabetes. It would be better to put efforts and resources into the other end. Specialists would continue to assess the most complex multi-dimensional problems and to manage specialist disease areas such as children and pregnancy. They would coordinate all the programmes and would run education and training. They would help to get evidence into practice, coordinate joint evaluation and take part in research and development. Above all, they could lead.

A more extended report on the Conference can be found in the April issue of Practical Diabetes International

Conference Report by James Wroe

CONTROVERSY

AACs. Dontcha Love Em?

Peter Daggett
Editor, ABCD Newsletter

I don't go to AACs as often as I should, because the usual request is to "come next week". Personnel departments don't seem to have spotted that consultants actually work during the day. When I do go, I find that the bigger the hospital, the less effort is made to make visitors feel welcome. Teaching hospitals are the worst and make it pretty plain that I am there under sufferance. The staff of St Humphrey's are quite capable of appointing their internal candidate, without some busybody from the sticks interfering. I arrive at the hospital and am greeted by a car park attendant, who tells me that the place where I have put my car is reserved for the Chief Executive. I am directed to a space full of broken glass, indicating the fate of the last person mug enough to park there. I make my way to the interview room, but it is empty. The sound of conversation is coming from an adjacent room, though, and I recognize one voice from outside. It's our old friend Professor Puff, explaining his latest idea called DAFT (Depression After Fibre Trial). My entry fails to stop him, but eventually the lay chairman suggests that we should start the interviews. She is the former head of a charity that helps the chronically constipated and ideally suited to the task ahead. There are three candidates, because only three applied. The chairman reminds us not to ask anything relevant to the job, because that might be regarded as discriminatory.

The first applicant is ushered in and Professor Puff kicks off. "What do you think of the role of dyslexics in planning research in my department – I mean the health service". The chap from Australia is flummoxed and Puff smiles. He makes a mental note that he must try this one again. Eventually it's my turn and I venture to ask about the effect of reducing junior doctors' hours on the running of diabetic clinics. This irritates the other panel members, who want to go home. The second candidate speaks with a regional accent, which is not at all the sort of thing that the staff of St Humphrey's expects. So we go on to the last applicant. Ah, says the chairman, Bethany, do come in. Could it be that this young lady is in with a chance? The interview is a breeze and we invite her to wait for our decision. Right, says the senior physician, any reason we can't appoint her – good, that's settled. I suggest that the body that I represent might want a little more discussion, but Puff and the others are putting their coats on. I am sent outside to "counsel" the unsuccessful pair and have to be careful not to tell them what actually happened. When I come back, the room is empty again and I set off back to the sticks, wondering why I have written off a whole day for this charade.

Interviews can't be the best way to appoint consultants, particularly if the outcome has already been decided. The group should be smaller, consisting of a representative from the Royal College of Physicians, with right of veto and two physicians from the hospital. The University representative should be dropped, because research experience has always been a questionable requirement and is now completely irrelevant. The chairman should be the Chief Executive and we should consign the lay chairperson to history. The group should do what they are presently not supposed to. That is, look at the references first and if they have any doubts, use the telephone to find out just how good (or bad) a candidate is. When a shortlist of three or four has been drawn up, all should be asked to visit the hospital informally and meet as many of the staff as possible. The staff and appointments group should then form a "hanging committee" and make a decision. The candidates would be spared the trauma of the interview (and the preceding trial by sherry) and despite the inevitable cries of "foul" from the equal opportunities industry, a better-informed appointment would be made.

APPOINTMENTS IN 2003

In the year to September 2003, 53 AACs were held. Of these, 11 were for posts having an interest in diabetes alone, with 42 in diabetes and endocrinology. This year, no posts were advertised in endocrinology alone. Analysis of the whole group shows:

Total AACs	Not appointed	New posts	Retirements	Vacancies
53	9	5	30	9

It is encouraging to see 30 new posts, perhaps suggesting that some Strategic Health Authorities are taking note of the NSF for diabetes. Seventeen of these new posts were in teaching centres and, interestingly, none of these advertised for a pure endocrinologist. The figures give the impression that in DGHs there is less enthusiasm for diabetes as a hospital-based specialty and there are stories of individual PCTs vetoing the creation of new posts in diabetes.

The bush telegraph suggests that that there is more fluidity in the consultant body than has been traditional and established specialists are leaving districts that do not support our discipline and going to ones that do. Local purchasers should note this and consider the consequences of abandoning our service. It is also clear that not enough trainees are available to fill the posts being created. The number of retirements will increase over the next five years, as the bulge of consultants appointed in the late '70s and early '80s reach 60. It is far from certain that the increase in SpR numbers announced over the past months will be sufficient.

I am very grateful to Linda Counter at the Royal College of Physicians of London for providing the raw data. Its interpretation and the comments above are my own.

Peter Daggett, Editor

SEND US LETTERS, NEWS, ARTICLES AND SUGGESTIONS

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

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

DETAILS ON YOUR ABCD WEBSITE!

www.diabetologists-abcd.org.uk

A more detailed report on the ABCD Autumn meeting appears in the April 2004 issue of *Practical Diabetes International* as well as on the ABCD website (address above), along with other interesting and useful information relating to the activities of ABCD and its members. If you have any comments or suggestions about the website, please contact the ABCD Website Officer, Bob Ryder on Tel No: 0121 507 4591 Email: bob.ryder@swbh.nhs.uk

Chairman's Report

Welcome to another newsletter. ABCD continues to prosper although we have run into a patch of troubled water recently. Unfortunately our London Secretariat is no more. When ABCD accepted a kind offer of support from Magellan Communications this was an enormous step forward for the Association. It gave us a London office base at minimal cost, a highly efficient secretary to run our database and organise mail shots and a conference organiser all rolled into one. However, as most of you will know, tragically our good friend and supporter Tom Delaney, MD of Magellan, died suddenly last November. We would like to extend our deepest sympathy to his family, friends and staff.

This disaster occurred just before our autumn meeting and almost had catastrophic consequences for us because some ABCD assets (meeting registration fees etc) held by Magellan were immediately frozen and our meeting was threatened with cancellation. Eventually it was rescued at the last moment by the expedient of several Officers and Committee Members underwriting the hotel bill using their credit cards! We are grateful to Ken Shaw, our redoubtable Treasurer, for organising the rescue operation. Happily the meeting then went ahead uneventfully and was well up to our usual standard. Our credit cards remained intact and we had just about stopped sweating by the time it finished. This unfortunate happening does mean that we are now looking for a new Secretariat. The Officer's long suffering personal secretaries are currently running the ABCD database and helping to organise the Spring meeting, our grateful thanks go to them.

My last Chairman's Message seems to have caused a few ripples. My suggestion that ABCD is becoming the "only game in town" for diabetes specialists did not go down well with some professional members of Diabetes UK. I do believe that my statement was and is factually correct. It was certainly not my intention that this should be construed as an attack on Diabetes UK. The Officers and Committee of ABCD would very much like to work more closely with Diabetes UK to provide support for specialist services. For several months we have been trying to organise a meeting with Sir Michael Hirst to see what the two organisations might be able to do together but regrettably we have been unable to find a suitable date until now. However, I am pleased to report that the Officers have finally managed to secure a meeting with Sir Michael and the professional officers of Diabetes UK during the spring meeting in Birmingham. Although there still appears to be some sensitivity about ABCD it is important to remember that most if not all of ABCD members still belong to Diabetes UK so there is no real conflict between the two organisations; we simply cater for different professional and lay interests within the same medical area. I feel that it is very important that ABCD and Diabetes UK do work closely together to provide the support for professional services that is urgently required, whilst preserving the identity and independence of consultants and SpR's. Most other medical specialities manage satisfactory symbiotic relationships between specialist professional and patient support organisations without any ownership problems and in my view there is no reason why diabetes should be any different. At the end of the day it is important that we both give consistent messages on matters pertaining to the quality and availability of both specialist and integrated services for diabetes patients.

There are many other issues concerning us at present including foundation hospitals, the new consultant contract, the working time directive, "asset stripping" of specialist services and not least the new GMS contract which is sure to have a huge impact on diabetes care. It is vital that all involved health professionals and patient groups work together to find a rational way forward through this quagmire and somehow or other end up with a better (not worse) service for our patients.

Richard Greenwood, Chairman, ABCD

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

MEMBERSHIP APPLICATION FORM FOR ABCD

HOW TO JOIN ABCD

About the Association and Membership

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

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

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

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

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

Membership Proposal Form

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

Please use block capitals

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