ISSUE 8 SPRING 2006

ABCD Newsletter

The Official Bulletin of the Association of British Clinical Diabetologists

EDITORIAL

With a little help from our friends

Peter Daggett
Editor, ABCD Newsletter

Whenever I go to International meetings, I am struck by the optimism of diabetologists in almost every country except ours. The Scandinavians have a population that is unbelievably compliant and which appears to have been bred specifically to allow medical trials to be organised. The Germans have patients who fall over themselves to give up their time for proper formal education. The Americans are habitually enthusiastic and cheerful. The drug companies are full of hope for the future, as are British GPs, academics and Diabetes UK. There is good reason to be up beat, because a raft of new treatments is on the way. We have new insulins, such as glulisine, with others on the horizon, and at least three new delivery systems. There are new drugs, such as the PPAR alpha/gamma agonist muriglitazar, and the GLP-1 enhancers like liraglutide. Many others are in development and we have the prospect of effective continuous glucose sensing not too far away. Beta cell transplantation is becoming a reality and once the molecular biologists have persuaded duct cells to differentiate properly, this may become a standard treatment.

UK specialists are highly trained and many of us have 20 or more years experience in the speciality. The collected wisdom of the ABCD membership runs into thousands of years and we are uniquely placed to influence opinion and provide the best services for patients with diabetes. Our voice is now being heard at governmental level and commentaries in the "Newsletter" are being quoted in other journals. Consultants in DGHs are nearly all miserable, though, and two pieces in this "Newsletter" from SpRs show

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

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that they have the same concerns. It is because we see our work of many years being eroded by PCTs that have not invested in hospital-based diabetes for a long time and who are now actively withdrawing funds. They take no notice of experts and listen only to their own advisers, who with a few exceptions have a very limited knowledge of the subject. Sadly, some of those involved in the dismantling of specialist diabetes services appear to be settling old scores and are using their new found powers to teach hospital doctors a lesson. Even academic units are being affected and we have heard that one of the largest diabetes services in the Midlands is under threat. Tony Barnett amplifies his concerns in this issue.

In order to improve specialist services for patients with diabetes, we must call in every favour from all of our friends. It seems clear that there will be no more money from PCTs or central government, despite the efforts of Sue Roberts. We should perhaps, look elsewhere and forge closer liaisons with the pharmaceutical industry. Our European and American counterparts have no such qualms about joining up with the manufacturers of products upon which we rely and I wonder why so many of us do have such qualms? Our improving relationship with Diabetes UK gives the two organisations an opportunity to state what we all know. Diabetes is a condition that cannot be managed with a cookbook. It needs considerable experience to decide which patients need the closest attention. Guidelines will always allow some high-risk individuals to be over-looked and their identification is properly within the remit of specialists. ABCD has tried to form a closer relationship with the EASD, for we need their support and perhaps Diabetes UK could join us in making representations to them. If we could persuade their committee to make a statement that specialists are essential, our case for being the leaders in the field would be strengthened. Anything European seems to impress the UK government and such a message, backed by two UK organisations would carry great weight.

ABCD SPRING 2006 MEETING

Wednesday / Thursday 5-6 April 2006
Crowne Plaza Hotel, Congress Road, Glasgow

- Following on from the 8th European Congress of Endocrinology, incorporating the BES
- RCP approved for 7 CME credits

For further details please contact Elise Harvey, Gusto Events Ltd, PO Box 2927, Malmesbury, SN16 OWZ Tel: 07970 606962
Or view the programme and download a registration form from the website: www.diabetologists-abcd.org.uk

Payment by results and the new tariff for diabetes services

A H BARNETT

Professor of Medicine, University of Birmingham and Clinical Director of Diabetes and Endocrinology, Heart of England NHS Foundation Trust

Our readers will share my concerns about proposed changes in the delivery of diabetes care. Planners hold the view that diabetes can be divided into "routine" and "complex" cases, that management is all about sugar control, that diabetes can be managed in primary care and that specialist knowledge can be obtained by sitting in a Diabetes Clinic or attending a course. They assume that there is good evidence that shifting care into the community is cost-effective and appreciated by patients and that community services have the capacity to absorb such work. Also that the shift of care will produce better clinical outcomes and that major reallocation of resources will not undermine specialist centres. I know of no such evidence and in fact there are many realities that conflict with this notion. I wonder also whether the Government has thought of the fact that forcing patients into one healthcare paradigm is diametrically opposite to the patient choice philosophy which is a central plank of their health policy. In truth, secondary care diabetes services could get "battered" as a direct result of the "shifting care" philosophy.

The final "nail in the coffin" for secondary care services could be the latest proposals from the Department of Health (DOH) on Payment By Results (PBR) and the National Tariff. Most diabetes care is outpatient-based and the outpatient tariff is based on attendance by speciality. There are separate tariffs for first and follow-up visits and the tariffs are derived from average 2003/04 reference costs for that speciality from all NHS providers. There are then uplifts to take into account price increases and specific NICE guidance and the average costs are determined across the NHS to allow a PBR system. The reference costs are supposed to cover all costs in delivering that specific service, including overheads and infrastructure.

As originally proposed, the tariff for follow-up diabetes cases was £61 per patient. Endocrine follow-up cases were costed at £95: the planners obviously do not understand diabetes! PCTs intend to pull out all "routine" cases, leaving only "complex" ones behind. Take a look, though, at the staffing of these complex clinics. We run, for example, multiprofessional clinics for foot care, renal, erectile dysfunction, obesity, adolescence, medical eye and antenatal. These will be paid for at the "average" tariff for the speciality. The DOH admits that its systems are not sufficiently robust to properly cost these services. The true cost of providing our services for diabetes follow-ups in 2004-05 amounted to £1.2 million pounds, effectively £95 per patient. If the proposed tariff price of £61 were enforced, it would produce a deficit of £439,000 for follow-up cases alone. That estimate however does not take into account the costs of "special/complex" clinics. Our true loss of income if this were effected would have been more than 50% of the total.

We asked our finance people to cost our multi-professional foot clinic properly. They allowed for consultants, specialist

registrar, diabetes specialist nurses, dressings nurses, healthcare assistants, shoe fitter and podiatrists. They also added non-pay costs for dressings, scalpels, x-rays, swabs, antibiotics, aircast boots and special shoes. They then added costs of patient transport. The actual cost of follow-ups for our foot clinic came to £186 and for our renal clinic, £114. The proponents of the scheme emphasise that the £61 is based on average costs supplied by trusts across the country, but these include "complex" and "routine" cases. If the diabetes National Tariff were enacted without proper costing and payment, quality of care would plummet and specialist services would close, because they couldn't be bailed out by other parts of the hospital. If the DOH has its way, there won't be any "routine" cases left in secondary care. So, we are left with "complex" cases, with costs based on the average for the whole diabetes community. Ultimately (as recently admitted by the DOH), PBR could pave the way for wholesale transfer of care to the private sector as, with no responsibilities for teaching, training or research, this will always be able to undercut the NHS.

So one should ask the question, "Where are complex cases going to be seen and who is going to provide the Centres of Excellence for patient care, teaching and research for the future?" The answer I got from the then Secretary of State for Health last year was "Negotiate locally with PCTs for advanced services". But the planners need to realise that secondary care services for diabetes are not a priority for PCTs – the DOH diktat is that diabetes patients should be managed in primary care. He also told me that it is the responsibility of PCTs to administer their budget as they think best for their local communities. Unfortunately, some don't comprehend the need to look at diabetes services as a whole, rather than what can or cannot be accomplished in primary care. Some have taken the proposals for "shifting care" to mean that virtually all diabetic patients should be discharged from secondary care, because they think that primary care will provide just as high a quality service. This means they do not see funding, let alone developing, secondary care services as a priority. Indeed there is, and will continue to be, a move to reduce support for secondary care services to facilitate these new proposals. This is not too surprising, where there is cash limited budget and insufficient resources for diabetes care as a whole. In developing PBR and setting the National Tariff at such a low level, the DOH is further compounding the problem and may well make it totally impractical to run high quality secondary care diabetes services at all. There is worse. Some PCTs have overridden decisions concerning referral pathways from GPs to hospital consultants and also between hospital consultants. The real sadness, though, is that the high quality care that is presently being given by specialists does in the long run reduce complications and is extremely cost-effective.

Many PCTs are working on a pyramid of care model that suggests that only 10% of patients should attend secondary care, 15% intermediate care (whatever that is), with 75% in primary care. There is, of course, no evidence base for these figures. In our area we have much deprivation and a significant ethnic mix, predominantly South Asians, whose standardised mortality rate is 150, compared with the national average of 100. This 50% excess mortality is almost entirely accounted for by type 2 diabetes and cardiovascular disease. We also have single-handed GPs looking after list sizes of 5,000 patients from the most deprived parts of the community. We have proposals for diabetes care which are not tried, not tested, and therefore not evidence-based. The new system should, at the very least, have been tested in pilot trials. It is my belief that what patients really want is a dedicated, multiprofessional, highly knowledgeable team which will respond appropriately and in a reasonable time to their needs. Isn't this what a good Diabetes Centre (either in the Hospital or Community) should be offering?

> **"It is my strong belief that the various professional bodies need to start speaking more on behalf of patients. They seem to be more concerned with what officials and politicians think"**

During discussions on diabetes services with one of our local PCTs, there was a clear statement within the policy document that there was no way that patients could be pulled out of secondary care in the foreseeable future because of the poor facilities and levels of expertise in primary care. The writer, a senior professional within the PCT, believed that the present community team did not have the resources to deliver the sort of comprehensive diabetes programme envisaged. The person considered that it would be unethical to remove patients from secondary care to this environment at the present time, i.e. once again we have a conflict between what could be perceived as Department of Health diktat and what is actually possible on the ground!

It is my strong belief that the various professional bodies need to start speaking more on behalf of patients. They seem to be more concerned with what officials and politicians think! It is my view that bodies such as ABCD should get heavily involved in negotiations with the Department of Health emphasising our major areas of concern about plans for diabetes care. We need to point out to them that if the National Tariff is not calculated properly to include the true costs of "complex" cases, then secondary care services will fall and that will be to the great detriment of care of diabetic patients. Politically, it won't look too good either!

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The tip of the iceberg… or am I just paranoid?

DR P S KAR

Specialist Registrar, Queen Alexandra Hospital, Portsmouth

It's been nearly four years since I became a Specialist Registrar in Diabetes & Endocrinology. I still recall the feelings of delight that I had gained the opportunity to train in my chosen field. The future looked bright, my parents thought I had finally come good and, yes, it was all so rosy.

So why is that four years into my training period, the sky doesn't t seem to be so bright anymore? My first instinct was that I was being unduly pessimistic, weighed down by the ever-increasing demands to juggle family and professional life. It was therefore a bit of a shock to find most of my contemporaries at a recent regional meeting were affected by the same doubts. All the concern and worry seems to be centered around one essential question: "What is my future as a Diabetes Consultant?"

Our practice of medicine has changed enormously since I was an SHO. Where shall I begin? First, the EWTD (European Working Times Directive), which aimed to improve living conditions and optimise training, has changed the way juniors work. The consequence of that change is that continuity of care has been confined to history and SHOs no longer receive adequate "on the job" training. Next, add the facts that pay scales have actually dropped and shift systems are unpopular. Finally, MMC (Modernizing Medical Careers) is with us and nobody seems to be sure how it will affect Specialist training. So there is a bit of a problem.

Importantly for us, the world of diabetes is changing too. Let's look at Primary Care. Undoubtedly, there is a shift of opinion about who is responsible for the care of the diabetic patient. General Practitioners with their new contract are being well supported by increasing numbers of specialist nurses, but are now expected to cope with nearly all patients with diabetes. This is, however, an ever-increasing problem.

Glance back at secondary care and you see once again specialist nurses doing much of the work. Quite rightly, there has been an increase in their numbers, but we are now looking at a future with independent nurse and pharmacy prescribing. This will remove much of our outpatient commitment. In-patient work on a diabetes firm nowadays is similar to old style geriatric medicine, with the odd smattering of diabetic or endocrine problems. Ask any SHO working on the Diabetes firm! One thing to remember is that Diabetes SpRs do not do any practical procedures, as do their counterparts in Cardiology or Respiratory Medicine. In short, they don't do much that hasn't already been done, or won't be handed over to GPs, Specialist Nurses or Pharmacists.

The nature of our training isn't a problem and most Registrars would agree that they are happy with what they receive. The big question doing the rounds seems to be "What next?" With PCTs mostly aiming to divert their resources (as far as Diabetes care is concerned) into Primary Care, it doesn't paint a very rosy picture for doctors who have spent the best part of their medical life training in Diabetes. The worry is that PCTs may not be interested in employing Diabetes Consultants for secondary care in the future. If you look at it from a Hospital Trust point of view, emergencies go to an admitting unit, while ward work is mostly specialty-based. Diabetes looks to be heading into Primary Care, so why bother to employ more Consultants?

Recent issues of the BMJ Classified seem to be highlighting early signs of a potential problem and starting to cause increasingly creased eyebrows for Diabetes SpRs. Kath Higgins, in the accompanying article, alludes to the fact that the quality of SHO recruitment to the specialty of Diabetes is not what is was. That issue will only be complicated by the uncertainty over the future of Diabetes SpRs. To simply say we have Endocrinology to fall back on, isn't enough. Let's face it; there isn't a huge increase of endocrine cases forcing PCTs to employ Endocrine Consultants by the dozen.

So, what could we be looking at in the future? Personally, I think there could be three outcomes to this. The wheel could turn full circle: the plan for pushing Diabetes Care into Primary care might come unstuck or GPs might be swamped by the sheer workload. That might force the authorities to revert to a balance between primary and secondary care. Or there might be a surge in Community Diabetologists, who will work as Specialists in the community. This might actually suit those who would prefer to stay away from acute medicine as well as giving them increased flexibility as regards family life. The last option is probably for people who would like to keep in touch with hospital medicine. This might involve taking a job in which Consultants do a few sessions a week on the admitting unit and spend the rest of their time as Diabetes Specialists. The flip side of that is whether one would like to do that for the rest of one's career.

Of course, these are all conjectures, but I would like to take this opportunity of highlighting the concern SpRs are starting to have. Even greater, is that of PLAB candidates struggling to find jobs, something which they will find increasingly difficult. Having been through that "trauma" myself, I never wish anybody else to be in such circumstances. The anxious wait for Friday's BMJ Classified is something I definitely do not want to go through again! I hope that we are not looking at a situation with plenty of qualified individuals scrambling for the few available Consultant jobs, due to a short sightedness in long-term planning. Believe me, I would rather be labeled a paranoid than someone having to worry about the next available job.

CONTRIBUTE TO YOUR ABCD WEBSITE!

www.diabetologists-abcd.org.uk

Powerpoint presentations from the last meeting can be downloaded from the website. Have you considered setting up a nationwide audit through the website? This can be easily achieved. There is also an area for on line discussions such as the one last year containing comments on the current problems with specialist diabetes services. Take the opportunity to make comments or share clinical observations on line. An similar ABCD SpR subweb for our trainees is currently under construction.

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

How can we attract junior doctors into our specialty?

DR KATH HIGGINS

SpR DM/Endo, Leicester Royal Infirmary, SpR Representative, ABCD Committee

It is apparent that junior doctors are not being attracted to our specialty[1], but in fact interest is declining in other acute medical specialties as well, with the exception of Cardiology. In Diabetes and Endocrinology, there is a perception of a fall in the quality of candidates[2]. How can we raise our profile amongst junior doctors and attract more applicants to advertised NTN posts? First, we need to understand what SHOs think about our speciality and what inspired our current SpRs to enter the speciality.

Senior House Officers

An anonymous study of 36 medical SHOs in Leicester (UHL) showed that there were many aspects of the speciality, which they considered attractive, and only two aspects that were considered unattractive (table 1). Forty-six percent of UHL SHOs had considered a career in DM/Endo but only 13% of this group planned to pursue this career path. Despite noting the attractive features of the specialty, the rest were not intending to seek a career in DM/Endo. At the SHO level, general/acute medicine commitment did not seem to be a significant factor when considering DM/Endo.

Specialist Registrars

In an anonymous survey of 21 DM/Endo SpRs from the Midlands the respondents were able to give free text responses regarding positive and negative features of a career in DM/Endo and to say what had inspired them to enter the speciality (table 2).

One third of the SpRs surveyed wanted to work part-time as a consultant, all female. Sixty-two percent felt committed to acute medicine at consultant level but 38% wished to opt for or to negotiate a reduced commitment; half of these were male.

Exposure and personalities

In order to attract junior doctors into our specialty we must increase their exposure to the attractive features, from which SHOs traditionally would have been excluded (for example, antenatal, adolescent, community and combined speciality clinics). They would then experience the interesting case mix, which inspired our current SpRs to apply for training posts. We should also allow them to attend the foot clinic, they may then see that there is vast scope for rewarding teamwork or active research in an area that they previously considered to be full of "no-hope" patients. Modernising Medical Careers and the introduction of the 2-year Foundation course poses a further challenge. We need to ensure that our specialty features in the early years of training, particularly F2. In the Leicester Royal Infirmary, SHOs currently only work on the Medical Admissions Unit in the daytime within a 4-month block of a rotation, thus theoretically allowing them more time in their ward placements to attend clinics. We have assigned one of our SpRs to mentor the SHOs in our team and we try to ensure that each of our two SHOs attends 2 clinics each week. The SHO either has a reduced list or attends as an observer. We hope that by facilitating this exposure, they will get an enjoyable and realistic exposure to the specialty, perhaps enough to develop a long-term interest.

The main feature that inspired SpRs surveyed to enter training in DM/Endo was the charisma and enthusiastic personality of a particular consultant, or SpR with whom they had worked. SHOs should be made to feel that they belong to an enthusiastic and supportive team. We should share the good and bad aspects of the job from a personal perspective and find time to do the simple things such as spending ten minutes chatting over coffee at the end of the ward round.

Aspects considered attractive by >50% SHOs:
Wide age range of patients, teamwork in multidisciplinary team (MDT), liaison with primary care, liaison with other hospital specialities, care of pregnant women, active research programme, treatable endocrine conditions, potential for laboratory/academic career, potential to treat rare/interesting endocrine disorders.

Aspects considered unattractive by >50% SHOs:
Care of the diabetic foot, no interventional procedures

Table 1. Leicester SHOs appraisal of the Diabetes Specialty

Positive features listed by > 4 respondents:
Interesting case mix (11), supportive team/collaborative environment (4), challenges of chronic disease management (6), working with the MDT (4), good educational network of meetings (4)

Negative features listed by >4 respondents:
General medical commitment/ on-call commitment (13)

Features which inspired entry into chosen career listed by >4 respondents:
Charismatic/enthusiastic consultants and registrars when SHO (8), interesting case-mix (6)

Table 2. Responses from Midlands DM/Endo SpRs on why they chose the specialty

Flexibility

Seventy percent of British medical students are women, as are 41% of trainees in our speciality. Many SpRs wish to work part-time and opt out of, or reduce, acute medicine as a consultant. We have a specialty which is ideally suited to flexible work patterns and I think recruitment into and retention within the specialty would benefit from developing innovative work plans for individuals who wish to work outside the "acute medicine + specialty" box. The newly qualified doctors entering Foundation Programmes currently are our potential trainees and colleagues of the future. It is up to us to attract and train enthusiastic juniors in order to maintain our speciality.

References

1. Daggett P. Where have all the trainees gone? ABCD Newsletter, Issue 4, Spring 2004.
2. K S Higgins & E M Scott. The recruitment crisis in diabetes and endocrinology. Diabetic Medicine 2005, Continuing Education Suppl. 4; 22: 9-13.

Highlights of the ABCD Autumn 2005 Meeting

Jury's Great Russell Street Hotel, London WC1, 27 October 2006

Welcoming 100 delegates to the Autumn Meeting, Chairman Richard Greenwood drew attention to ABCD initiatives on the future direction of specialist diabetes services and ways of helping diabetologists influence commissioning, in the light of Payment by Results and National Tariffs. Good progress was being made with the 2nd ABCD Survey of Specialist Services, using a web-based questionnaire. Pilot MINAP data on hyperglycaemia in ACS had been released to the ABCD website. Support from the pharmaceutical industry was confidently expected for the ABCD Clinical Audit programme to be continued. ABCD would again be providing citations on request for members applying for higher Clinical Excellence Awards.

THE ABCD LECTURE: ROLES AND RISKS OF CONTINUOUS INSULIN PUMP THERAPY IN TYPE 1 DIABETES

Professor Stephanie Amiel, Professor of Diabetic Medicine, Kings College, London

After initial interest in CSII in the late 1970s, there had been a u-turn in opinion in the UK, largely as a result of DKA, associated with the rather primitive technology of pumps at that time. Insulin pumps nowadays were much smaller and more reliable and were widely used in the USA and in parts of Europe. Use in the UK was currently only 1-2% but was increasing. NICE (Feb 2003) had recommended pump therapy where multiple doses of insulin failed in a competent patient who did not have disabling hypos, provided initiation was carried out by a trained team. A meta-analysis by Pickup in 2002 of 12 RCTs showed a mean reduction in HbA1c of 0.51% and in the risk of nephropathy of 25%, and reduced glycaemic variability. Bode in a paper published in 1996 found that severe hypos were reduced with pump therapy.

In Professor Amiel's centre, initiation of pump therapy had brought about the restoration of hypo awareness in one patient and restoration of CSII had halted the progression of retinopathy in another. In a third case, pump therapy had had to be stopped because of DKA. Of the 39 patients on pumps at Kings, 14 were due to hypos and 25 to other problems. Fifteen had NICE contraindications to CSII. Pump therapy had brought down HbA1c and the incidence of DKA and severe hypos. Fifty per cent of the patients on pumps at Kings had the DAWN phenomenon and CSII had dealt with this successfully. CSII was a very good way of taking insulin if one was fully motivated but it was not cheap. In the USA 60% of health care professionals who had diabetes were on pumps. In conclusion, Stephanie Amiel said pumps generally produced a modest improvement in HbA1c and glucose lability and some improvement in quality of life. In patients with recurrent severe hypos this could be dramatic. In an experienced multidisciplinary setting, including psychiatrists and psychologists, it could help with a number of other diabetes factors. But it should not be regarded as a terminal therapy, simply as another option in T1DM.

"If we practised medicine in the same way as politicians practise health care, we would be struck off."

Dr Jackie Davis, British Medical Association

Box. (A. Barnett)

THE ABCD DEBATE: HBA1C IS NOT A SUFFICIENTLY RELIABLE MARKER OF GLYCAEMIC CONTROL IN DIABETES CARE

Chair: Dr Anne Kilvert (Northampton)

William Jeffcoate (Nottingham), proposing the motion, admitted the close correlation between HbA1c and mean plasma glucose in a single individual. But the HbA1c assay was not a uniform measurement. It had been harmonised but not standardised. And HbA1c did not necessarily correlate with mean plasma glucose between different individuals. The rate of glycation was dependent on a number of factors in the life cycle of the red blood cell. Some people had a high glycation and some a low glycation rate. Those with the former were at much greater risk of microvascular complications. In summary, Dr Jeffcoate maintained that HbA1c might be a good measure in populations but was not standardised and was an inconsistent marker of glycaemic control in individuals.

Sally Marshall (Newcastle upon Tyne), opposing, said that in EDIC, a follow-up to DCCT, those who had received intensified therapy and therefore lower HbA1c during DCCT had less events and complications. Therefore HbA1c helped relate glucose control to long-term complications. Harmonisation had reduced the differences in HbA1c assays in different parts of the UK to 3% nationally. They could therefore be compared. The situation was much better than with BG measurements, where there was very little quality control. CGMS could also produce significant variations. So far as variation between different people was concerned, the important thing was that the higher HbA1c was in any individual, the greater the risk. In conclusion, HbA1c remained an extremely strong indicator of micro and macro complications and did not present a great problem in the vast majority of patients.

At the end of the debate, those in favour totalled 48 and those against 47, a similar proportion to the pre-debate vote.

TARIFFS FOR SPECIALIST DIABETES SERVICES: THE FINAL NAIL IN THE COFFIN?

Professor Anthony Barnett, Professor of Medicine, University of Birmingham

There was no question in Tony Barnett's mind that specialist diabetes services were starting to be systematically starved of resources. No account was being taken of major geographical and ethnic differences between patient population areas or of the effects of the "cuts" on research and teaching. In the new Outpatient Tariff, £61.00 was being offered for diabetes follow-up. This payment was based on the average diabetic patient, whereas by definition hospitals tended to see more complex cases, and on an acute care model, quite unsuitable for chronic disease management. Professor Barnett calculated that the new tariff would lead to a 50% effective loss of income for his centre. The concept of "patient choice" in the NHS was meaningless if patients could not get themselves referred to consultants.

Comments by Sue Roberts, National Clinical Director for Diabetes:
Sue Roberts assured the meeting that it was not government policy to move diabetes care wholesale from hospitals to PC. She agreed that Payment by Results could be difficult to understand but said this problem was recognised by the National Diabetes Support Group and the DH. She had distributed a paper at the meeting, which contained helpful suggestions on ways of solving problems for hospital centres.

OTHER PRESENTATIONS AT MEETING

Impact of oestrogen therapy on diabetes and vascular risk - *Dr Helen Buckler, Consultant Endocrinologist, Hope Hospital, Salford, UK*
Antiplatelet effects of rosiglitazone; a direct consequence of platelet PPAR gamma activation- *Dr Manish Khanolkar, Llandough Hospital (winner of the ABCD SpR Training Award 2004)*
ABCD Survey of services for gestational diabetes - *Dr Fahmy Hanna, University Hospital of North Staffordshire*
Findings and implications of the PROACTIVE Study - *Professor John Betteridge, Professor of Diabetes & Endocrinology, The Middlesex Hospital*
Anti-psychotic drugs and diabetes: genuine concern or industry hype? - *Dr Richard Holt, Senior Lecturer, University of Southampton*
Links between oxidative stress, inflammation and diabetic vascular disease - *Professor Naveed Sattar, Consultant Clinical Biochemist, Glasgow Royal Infirmary*

Conference Report: James Wroe

CONTROVERSY

Alternative Medicine

Peter Daggett
Editor, ABCD Newsletter

I don't understand why apparently intelligent adults should believe that extract of compost heap should have any therapeutic action. Quite a lot do though. The men usually have beards and play a guitar. The women wear sandals and knit their own yoghurt. They are encouraged by the support of a man that talks to plants and who once confused a piece of modern architecture with a skin disease. While looking for the local branch of Cynics Anonymous, I recently blundered into a shop selling herbal remedies and was amazed by what was on offer. If you want a good laugh, go and have a look at the shelves of your local "Herbs are Us". Apparently, plants that sound like the part of the body afflicted can be used in a system of healing called phoneopathy. Thus excessive belly button hair is treated with Umbellifera, sore eyes with Iris extract and urinary infections with Peony, while Fuchsia is a sovereign remedy for gynaecological disorders. On the next shelf are the Chinese medicines, including snake penis capsules – I promise, they do exist. These are advised for "diseases of the person", but if they don't work there is Ginseng to help you remember where to stick your Viagra. Finally, there is the100 year old jellyfish, which is good for flatulence and which is conveniently situated next to the Phar Ting fungus balls that cause it. Homeopathy is another source of wonder and I particularly liked the bottle containing a solution of silica. The silica in the glass is actually soluble, with a solubility product of 3.6 x 10-37 (I thought you would be impressed by a bit of real science). That means that more SiO2 comes from the bottle, than the Mickey Mouse "dilution". The punters are actually paying for distilled water. I am clearly in the wrong job.

I wish I had thought of flogging bits of cheap coloured glass and calling them crystals. These are much sought after by the thinkers of Hampstead, who appear superficially to be quite normal, but who must have an IQ about the same as the pH of their urine. They believe that the magic rays coming from the crystals will soothe them and help their pets to communicate with their ancestors. When they come to see me, they use the crystals to find an especially busy clinic and then spend 30 minutes telling me their bad experiences of orthodox medicine. The ancient medical practices of uroscopy and stool gazing did have some very slight physiological basis, but who on earth decided that examination of the feet could be used to establish what was going on inside the abdomen? Pressure over the metacarpals (anatomy is not this disciplines strong point) allows the state of the spleen to be divined. More usefully for our specialty, the skin turgor on the soles of the feet can be used to gauge adrenal function. So much simpler than old fashioned biochemistry, but actually more expensive. Iridology at least gives the possibility of being used to spot rubeosis and signs of glaucoma, but of course, it isn't. Spots on the iris indicate trouble elsewhere, perhaps in the feet. Physicians and surgeons do sometimes talk to each other, but peddlers of alternative medicine never do. I wonder if that is because they each recognise that the other is a fake. Finally, we must not forget meditation and new age activities. Tantric Buddhism is popular, but how many people know that its definition includes "sexual pantheism"? Whatever that actually is, is sufficient to block access to it through hospital systems, so if not useful, it might be fun.

The flight from science really seems unfathomable. Those determined to ignore orthodox medicine are often the first to criticise when things go wrong. On the one hand, they will draw a pentacle around themselves and put on a pointy hat in order to cure themselves of some imaginary ailment. On the other, they will appear in our clinics with a real disease like diabetes, expecting that a proper doctor will make them better. They will moan and groan when that is not done quickly enough, but wouldn't dream of telling one of their quack advisers that they are useless. We are so frightened of upsetting people and getting into trouble with the GMC, that we allow the snake oil merchants to get away with it. I propose that our profession does the unthinkable and tells the truth. See you in court!

* *tincture of old rubbish*

Chairman's Report

The Association continues to grow healthily, helped by the recent surge in new SpR members. This welcome development has reduced the average age of members to below 50 and, reflecting this overdue change in our constituency, we now have an SpR representative, Kath Higgins, on the Committee. The increased membership does, however, make the organisation of meetings more complicated and to address this problem, the Association has reached agreement with Gusto Events to provide more permanent administrative support. Our next meeting will be held in Glasgow on April 5th – 6th. Once again we will be meeting back to back with the endocrinologists, this time as part of the 8th European Congress of Endocrinology. Last year's meeting with the BES in Harrogate was a success so we have decided to continue with the arrangement. This will, however, restrict the number of meeting locations, especially if we stay with the BTA in London in the autumn. In view of this, the Committee is considering making the spring meeting with BES an alternate year event, in order to give us more flexibility in choice of venue.

The Association continues to wrestle with a range of issues, including Payment By Results, Choose and Book and Practice-based Commissioning. In order to address these effectively, ABCD has formed useful relationships with the National Diabetes Support Team (via the Specialist Service Liaison Group) and Diabetes UK. We have recently published a Joint Position Statement, entitled "Ensuring Access to High Quality Care for People with Diabetes" and this is available on our website. You may find it useful in persuading your managers, PCTs and local patient groups that adequately resourced specialist diabetes care is an essential component of all local health services. Without it, primary care will struggle, quality will decline and 'patient choice' will be compromised. This was emphasised by Colin Kenny in his recent BMJ editorial, which coincided with the launch of the Primary Care Diabetes Society (PCDS). ABCD welcomes this important development and looks forward to working constructively with PCDS to promote effective integrated care for all of our patients. I should like to draw your attention to two important ABCD initiatives. The first is a repeat of the Survey of Specialist Care Services, which this time will be a joint exercise with Diabetes UK. The questionnaires will be sent out shortly. Please help by completing and returning them as soon as you are able. Reliable information about our services is vital and we can only get this if there is a decent response rate. The second is the ABCD Audit programme and I am delighted to report that Sanofi-Aventis have agreed to fund this for a further three years. Further information is available from Peter Winocour.

Sadly, the Glasgow meeting will be my last as Chairman of the Association, because I shall be retiring from the NHS in May. Like John Wales, I feel that in order to be in touch with all the clinical and political issues of the day, the Chairman should be a practicing clinician. Helping to found and develop the Association successfully, in the face of stiff opposition and numerous difficulties, has been the most satisfying achievement of my professional life. There is no doubt that ABCD is now a force to be reckoned with. Now Ken Shaw will be the only one of the original "gang of three" left in office. He will be able to provide continuity during the next few years whilst the Association continues to evolve. It goes without saying that I am grateful to all of my colleagues, especially the Officers and those who have served on the Committee, for helping me to survive as Secretary, then Chairman. I should also like to acknowledge the support of friends and colleagues from the pharmaceutical industry, especially Peter Robinson (Bayer and now Takeda), Jeff Goulder (Novo Nordisk) and Martin Jones (Lilly), without whose help we would have found it very much more difficult, not only to get started, but to remain in existence.

Richard Greenwood, Chairman ABCD

There will be many tributes to Richard's work, but I would like to thank him personally for everything that he has done to help me. He has politely revised some of my more immoderate scribblings and contributed not only his Chairman's column (usually on time), but also the Associations logo. Richard, thank you very much. Ed.

MEMBERSHIP APPLICATION FORM FOR ABCD

Membership of ABCD is open to all Consultant Physicians with an interest in diabetes patient care in the NHS and all SpRs in Diabetes and Endocrinology. At present, the annual membership fee is £25.00. If you are interested in joining the Association, please fill in the application form below and return it to the ABCD Membership Co-ordinator at the following address:

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

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

Membership Proposal Form

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

Please use block capitals

Name (in full, please)

Professional Qualifications

Position held

Address

/ Post Code

Tel. No.

Fax No.

Email

Signed

Date