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Diabetic supervision

Sir,

I am a member of the Medical Advisory Committee of the British Diabetic Association and we have recently discussed the professional supervision that all adult diabetic patients should expect to receive. Our recommendations are shortly to be published in *Balance*, the monthly magazine for diabetics, and I feel it important that all general practitioners know of these recommendations, since patients will want to discuss some of the points made.

At the time of diagnosis an adult diabetic should expect:

- a full medical examination;
- an explanation of the nature of the condition and of the treatment likely to be required;
- an interview with a dietician to ascertain previous food intake followed by dietary guidelines and the provision of written dietary advice; the arrangement of a follow up for more detailed dietary advice;
- an explanation of the need and provision of the means to monitor the condition, that is urine or blood testing equipment. At this stage further education should be made available. Patients may find it helpful to obtain one of the BDA handbooks;
- advice to inform the DVLC and insurance company (if a driver) and advice concerning exemption from prescription charges;
- initiation of treatment.

Initially patients requiring insulin will need to be seen frequently by a specialist nurse or doctor but they will rarely require admission to hospital. Basic instruction must include injection technique, management of insulin and syringes and how to monitor progress. Hypoglycaemia must be discussed and understood; when it may occur, how to recognize it and how to deal with it. Ketone testing equipment may be provided as well as glucose monitoring equipment and the significance of ketones explained. The education process should continue, to explain how insulin, food and exercise affect blood sugar and how other aspects of life may alter diabetes control.

Patients treated with diet and tablets may need to be seen fairly frequently initially by a specialist nurse and dietician for education, reassurance and evaluation of the effectiveness and understanding of treatment and advice.

In the long term all patients whose diabetes is reasonably controlled should be seen by a specialist nurse, doctor and dietician at regular intervals. The intervals will vary according to individual needs. Some people may only need to be seen annually while others, for example children, should be seen at least three monthly and pregnant mothers weekly. Ideally direct access to specialist advice from a doctor, nurse, dietician or chiropodist should be available between arranged visits to solve problems as and when they occur. Sufficient time should be allowed at visits for adequate assessment, general discussion, advice and continued education.

All diabetic patients should be seen by a doctor annually for a formal medical review. At such a visit weight will be recorded, urine tested for glucose, ketones and protein, and a blood sample taken for glucose and HbA1 measurement. Patients should bring a record of home monitoring results and their blood pressure should be measured. Vision should be checked and the retinae examined after the instillation of dilating drops. If the doctor is at all concerned, the patient should be asked to see an ophthalmologist. The feet and legs should be examined to assess the state of the circulation. They should also be examined for evidence of neuropathy — reflexes and sensation to touch and vibration being assessed. Injection sites should be examined if patients are receiving insulin. An electrocardiogram or heart tracing should be performed as a routine check on people over the age of 40 years or who have had diabetes for more than 15 years. General aspects of coping with life both personally and at work should be discussed. At such annual visits people should also have the opportunity to see the dietician/specialist nurse/chiropodist for further advice. Further visits may be arranged before the next annual review as necessary.

Control of diabetes and the detection and treatment of complications is so important that general practitioners should ensure that patients receive this recommended minimal care.

PETER R.W. TASKER

St James' House Surgery
County Court Road
King's Lynn
Norfolk PE30 5EL

Diabetes mini-clinic

Sir,

Diabetes has traditionally been managed by hospital clinics, which tend to be overcrowded and rushed with poor continuity of care. Even shared care with the hospital is sometimes inadequate. The concept of complete care in general practice mini-clinics began in the 1970s, and has been shown to produce metabolic control comparable to hospital clinics. The care of diabetic patients must become increasingly the responsibility of general practitioners. It is a common condition, and with some training, management in the community can provide great rewards for both patient and doctor.

In April 1986 my practice, which is in a multiply deprived inner city area, set up a diabetes mini-clinic. Diabetic patients from the practice population of about 13 000 were invited to register with the clinic, as were those diagnosed since the clinic began. Not all known diabetics have yet been included in the register. The clinic is attended by a hospital physician, a practice nurse, a dietician, a diabetes specialist nurse and myself and is held monthly. Ten to 12 patients are booked at 10 minute intervals.

The practice nurse sees the patient first and tests the urine for protein, glucose and ketones. She weighs the patient, checks the blood pressure and visual acuity and checks the blood glucose by B-M Stix. The nurse also uses the opportunity for health education. The patient then has a

joint consultation with the general practitioner and hospital doctor. An overall view of diabetic control is made, and blood is taken for glycosylated haemoglobin estimation if necessary. Once a year a more detailed examination takes place which involves careful scrutiny of the optic fundi after dilating the pupils with tropicamide eye drops, followed by examination of the feet for evidence of arteriopathy or neuropathy. If necessary serum creatinine, haemoglobin and thyroxine levels are tested. Referrals are made when appropriate to the ophthalmic or vascular surgeons, nephrologist, cardiologist or chiropodist. The patient then sees the dietician and diabetes specialist nurse either together or separately for detailed advice on all aspects of diabetes and its management.

The criteria we use to assess the standard of our diabetic care are the glycosylated haemoglobin levels, body mass index and detection of complications. Results were taken 15 months after the clinic began and of the 56 patients registered, 12 were insulin dependent diabetics, and 44 were non-insulin dependent diabetics. During this time three insulin dependent diabetics and five non-insulin dependent diabetics have been newly diagnosed. Insulin treatment was initiated at home under the supervision of the GP and the diabetes specialist nurse. Four patients have returned permanently to hospital diabetes clinics out of preference, and three because of advanced complications.

The mean age of the insulin dependent diabetics was 51 years and they had had diabetes for an average of 10 years. Their body mass index and glycosylated haemoglobin levels did not alter greatly but 10 new complications were found.

Non-insulin dependent diabetics had a mean age of 61 years and had suffered diabetes for a mean of five and a half years. Mean body mass index fell by 1 kgm^{-2} to below 30 kgm^{-2}. Glycosylated haemoglobin levels were only slightly changed and 22 new complications were found. There was a total of 11 separate referrals in eight diabetic patients. Thirteen patients had co-existing hypertension.

It is too early to draw a firm conclusion from 15 months' experience of the clinic. There was little change in the metabolic control of either type of diabetic and it is disappointing that there was no improvement in the glycosylated haemoglobin levels but they at least remained stable. Patients' body mass indices were also little affected, although it was gratifying to see the mean for non-insulin dependent diabetics fall below 30 kgm^{-2}, the level for frank obesity. The increase in body mass index in those insulin dependent diabetics who originally had a low index is a measure of the improved glycaemic control. However our main claim to success is the large number of complications identified in the diabetics. This allows early referral if necessary, or intensive education, for example in foot care. The involvement of primary care workers and a hospital physician provides a unique combination of generalists' and specialists' expertise as well as greater continuity of care. It has also proved to be a useful learning experience for all the professionals involved, trading knowledge and skills to the benefit of all concerned. The demonstration that a diabetes clinic can work will hopefully encourage other general practitioners to consider setting up their own.

IVAN BENETT

Hulme House
Royce Road
Manchester M15 5FR

British Diabetic Association

Sir,

With the increasing interest of general practitioners in treating their diabetic patients I would like to draw the attention of readers to the British Diabetic Association and what it is able to offer, not only to patients, but also to general practitioners looking after them.

The Association is 53 years old this year and is the oldest of the patient associations in this country. In addition to providing advice for patients through its diabetic care, diet, youth and information departments in London, it has more than 300 branches and groups scattered through the UK. It has a medical and scientific section for nurses, dieticians and chiropodists and, recognizing the importance of patient education, it has recently added an education section. The BDA is anxious to establish links with general practitioners and is in the process of compiling a list of those general practitioners interested in the care of diabetic patients, so that they can regularly be sent details of developments that may interest or help them.

Any general practitioner who would like to be added to the register, should write to the British Diabetic Association, 10 Queen Anne Street, London W1M 0BD.

JOHN NABARRO

British Diabetic Association
10 Queen Anne Street
London W1M 0BD

Inter-practice visiting

Sir,

Peer review is usually taken to mean the critical assessment by contemporaries of the standards of the doctor being assessed. But visiting a colleague's practice is not only useful for the doctor visited but is also a way of broadening the experience of the reviewer and such a visit need not incur any criticism of the reviewed practice. Although figures are not documented, it seems probable that family doctors rarely visit their colleagues. In a preliminary enquiry we found that 12 out of 18 doctors had not visited another practice in the previous five years.

In order to assess the feasibility of such visits and the benefits to the visitor as well as the feelings of the practitioner visited, the trainers in all 15 training practices in Gwynedd and the principals in two other practices interested in training were randomly allocated two training practices to visit in three months. Each practice made contact with four different practices, two as host and two as visitor. Only one principal made each visit but both visits were not necessarily made by the same person if the practice had more than one trainer. Five topics were suggested for discussion (premises, appointments systems, teaching methods, records and one topic chosen by the visitor) but the emphasis was on informality and no rigid structure was imposed. After each visit the guest and host completed an anonymous questionnaire.

Of a potential 34 visits 28 (82%) were undertaken. The average return distance travelled by the participants was 57 miles. One guest's questionnaire was mislaid.

All 27 guests described the visits as enjoyable (very, 18 guests; quite, nine) and interesting (very, 17; quite, 10). There was no relationship between enjoyment and the distance travelled by the visitor, with those describing their visits as very enjoyable travelling on average 56 miles and those whose visits were quite enjoyable travelling 58 miles. Similarly, the amount learnt does not seem to have influenced the enjoyment of the visits. After the 18 visits described as very enjoyable six visitors said they had seen several things they would try to introduce into their practices, six one thing and six nothing.

All the visitors had learnt something and six said there were several things that they would try to introduce into their own practices and 10 said there was one thing. After all the visits were complete 89% of the doctors said that they thought the idea of making the visits was very worthwhile and 11% quite worthwhile.

No one found being visited threatening and all the hosts described the visit as enjoyable (very, 26 hosts; quite, two). The majority (19 hosts) felt the visit was helpful to their practice and after the visits 89% felt the principle a good one and 11% quite good.