

should be at hand during this time. In small units, the expense of providing the minimum drugs (adrenalin and hydrocortisone), intubation and ventilation equipment, and ECG and defibrillator will readily be borne by Leagues of Friends, rather than lose a valued local service. Radiologists in administrative charge of these units will find no difficulty in ensuring that their conditions are met.

Carping of this nature should not detract from the value of the Report. There is now no excuse for the niggardly approach to x-ray provision which has been adopted in all too many areas in the past. At least one authority has adapted the more restrictive recommendations of the Report into practical working arrangements which maintain services at the pre-existing level. Granted the essential—and all too rare—qualities of determi-

nation, goodwill and common sense, there is no reason why such arrangements should not become universal.

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Diet and diabetes — all is confusion. Or is it?

IT is still widely taught and practised that good diabetic control cannot be achieved with a diet containing more than 40 per cent carbohydrate (Truswell *et al.*, 1975). This generally false approach is based upon the Western concept that the symptoms are primarily caused by a disorder of carbohydrate metabolism. Since insulin began to be used nearly 60 years ago there has been no need for carbohydrate to be virtually excluded from the diet of the severe diabetic, and interest in diet has waned considerably. It is only more recently that the lessons to be learnt from diabetic diets in Asia and Africa are being heeded. Patients in these countries are fed diets containing between 70 and 80 per cent carbohydrate with no obvious ill-effects (Patel *et al.*, 1969) and the mortality from large vessel disease in Japanese diabetics (but not those that settle in the United States) is one tenth of that of their Western counterparts (Goto and Fukuhara, 1968). These diets contain no more than 10 to 12 per cent fat, whereas low carbohydrate Western diets often contain as much as 40 per cent fat. There is, however, no such marked discrepancy between East and West in the incidence of microvascular disease, which is more directly related to the length of exposure to hyperglycaemia.

To minimize the complications of diabetes—large vessel and microvascular—the dietary changes must be made in two ways. Firstly, the total energy intake should be just adequate to maintain the well-being and ideal weight of the Type I (insulin-dependent) diabetic, but below this requirement for the overweight, Type II (non-insulin-dependent) patient (Thomas and Powell, 1980). It is often believed that blood glucose is affected by carbohydrate intake alone. Dietary carbohydrate certainly has the most immediate effect on blood glucose, but the subsequent contribution made by other

foods, particularly if the total energy intake is more than adequate, is substantial (West, 1973). Regulation of total energy intake is now thought to be more influential in controlling diabetes than any one food in particular (Arky, 1978). Secondly, the unabsorbable fibre content should be kept high (Kiehm *et al.*, 1976); fibres from a leguminous source seem to have the best reducing effect on post-prandial hyperglycaemia (Jenkins *et al.*, 1976, 1977, 1978; Simpson *et al.*, 1981).

Reduction in cholesterol intake (as against that of total fat) is pointless, since such reduction is compensated for by a rise in the amount absorbed. Eggs, being a cheap source of protein fairly low in fat, should form an important part of a diabetic diet, but special 'diabetic' foods should not. Patients dislike diets; they particularly dislike those containing large quantities of fibre. Yet to be effective in reducing post-prandial hyperglycaemia significantly, diets for diabetic patients need to contain at least five times the normal amounts found in typical Western foods (Simpson *et al.*, 1981).

So, how best can we apply the research findings to the practicalities of everyday diabetic life? The following guidelines, based on Thomas and Powell (1980), are worth considering.

1. Regulating total energy (calorie) intake appears to be a better way of managing diabetes than simply restricting dietary carbohydrate.
2. Within the individual's agreed intake of energy, a diet high in carbohydrate (60 to 70 per cent) and low in fat (15 to 20 per cent) may prove beneficial in the prevention of cardiovascular (large vessel) disease.
3. Reduction of hyperglycaemia and the risk of microvascular complications is more likely to be achieved if the dietary fibre content is substantially increased.

Much work still needs to be done to improve the acceptability of these foods to the majority of patients.

4. Dietitians, as responsible practitioners in their own right, have a large part to play in trying to improve patient compliance.

The fundamental aims of managing diabetes are to maintain the well-being of the patient and to prevent or, at worst, delay the onset of complications. There is much to be said for having diabetic clinics in general practice, since they not only bring together the doctor, the nurse, the health visitor and the dietitian, but they also impose on the doctor a relatively uninterrupted discipline of thought and behaviour, almost impossible to achieve in the hurly-burly of the average surgery. In this way, procedures are more likely to be carried out and less is likely to be missed. The records will need to be kept in a way to make audit of management relatively easy and simple. Neither we nor our patients need to be reminded of the unsatisfactory, frequently near-chaotic conditions that prevail in many hospital diabetic clinics. Even if dietitians are not available to help, their advice is, so all but a few diabetics can, and should, be managed in their practices by their doctors and their teams. Is this kind of diabetic care not part of a general practitioner's job?

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Every child a wanted child

ALTHOUGH there is a large literature on contraception and sexual behaviour, extremely little research has come specifically from general practice, and no attempt has been made to review the whole subject. The publication of the College's fourth Report on Preventive Medicine (the previous three—on health and prevention, and on the prevention of arterial disease and psychiatric disease—were published in February 1981) is therefore most welcome. This short monograph is a statement of what the primary health care team can be expected to do. The working party points out that good family planning proceeds from the recognition that the entire practice team should be involved in providing the service. It points out that the special needs of all at-risk groups should be identified clearly, and that the skills of the whole team should be directed to meet these needs.

These opportunities to practice preventive medicine, however, should be balanced against their possible effects on contraceptive practice. Screening procedures should not be insisted upon if they are likely to discourage either a subsequent visit or the effective use of contraception. Although many more women go to their family doctor for contraceptive advice than go to Area

Health Authority or Health Board clinics, there is, nevertheless, still a large and continuing need for training. The working party recommend that all vocational trainees in general practice should train to the present standard of the Certificate in Contraception and Family Planning, but they also recommend that part of this training should be carried out in general practice.

Contraceptive behaviour is a kind of final common pathway, the expression of a woman's or man's most intimate beliefs and fantasies. Such behaviour can never be entirely rational, and it is vital that general practice is organized in such a way that it can cope with all the demands our patients are likely to make on us. This latest Report from General Practice, which is a document that Council has approved as a statement of College policy, provides the evidence on which we can base our planning of such a service.

Family Planning—An Exercise in Preventive Medicine. Report from General Practice 21, is available from the Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU, price £2.25, including postage and packing. Payment must be made with order.