

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.

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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
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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.