that we had only identified 0.7% of our list as being diabetic and also that the majority of parameters which should be regularly measured in all diabetics had been measured in under two-thirds of patients (Table 1).

This was discussed in a practice clinical meeting and a decision was made to improve our level of diabetic care. Five out of six of the partners decided to refer their patients to a diabetic clinic run weekly by one partner and the practice chronic disease sister. The clinic used a protocol agreed by the majority of the partners and by 1986 the care of the patients had improved according to most of the parameters measured, though this trend was more noticeable in the patients looked after in the practice diabetic clinic than in those looked after in normal surgeries (Table 1). However, in 1987 patient care had deteriorated from the 1986 level (Table 1) although more diabetics had been diagnosed and more patients were being cared for in the practice. Fewer patients were seen and the intervals at which they were seen had increased. Examination of patient notes suggested that this deterioration in care was partly due to an unwillingness on the part of patients to attend regularly and partly to a decrease in the enthusiasm of the staff running the clinic and the call and recall system.

It would seem from this small survey that if the Government wishes to improve the quality of care of patients in general practice, it ought not only to aim for an increase in the range of services and the number of patients receiving these services but it should also encourage a widespread system of quality maintenance, probably based on peer review. Without a further audit of our diabetic care, I suspect that we would have continued to have been a rather self-satisfied and smug practice, secure in the conviction that our care for diabetic patients was second to none.

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References

1. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Promoting better health (Cm 249).* London: HMSO, 1987.

Table 1. Results of audits of diabetic care carried out solely in the practice in 1984, 1986 and 1987.

Follow up procedure	Percentage of patients cared for in the practice diabetic clinic		Percentage of patients cared for in normal surgeries		
	1987 (*n*=62)	1986 (*n*=43)	1987 (*n*=14)	1986 (*n*=18)	1984 (*n*=63)
Smoking habits recorded	77	81	85	94	46
Cholesterol level recorded in last:					
8 months	84	93	7	61	7
12 months	92	100	7	61	7
Urine tests in last 8 months	87	93	71	72	64
Fundus examination in last 8 months	89	95	29	22	49
Tonometry in last 12 months	5	86	0	0	37
Visual acuity in last 12 months	89	98	7	5	No record
Examination of feet in last 8 months	87	81	21	28	No record
Neurological examination in last 8 months	84	93	0	22	No record
Blood pressure recorded in last 8 months	85	88	57	100	58
Blood sugar recorded in last 8 months	87	86	79	88	66
Creatinine recorded in last 8 months	84	51	14	5	No record
Urea level in blood recorded in last 8 months	84	100	64	67	41
Weight measured in last 8 months	85	100	64	78	69
Haemoglobin A_{1C} concentration recorded in last 8 months	82	100	21	28	12
Treatment plan defined	95	100	43	5	No record
Full diabetic check in last:					
8 months	84	93	79	61	No record
12 months	92	100	79	61	No record

n = number of diabetic patients.

Medical services for epilepsy

Sir,

A recent government report into services for epilepsy[1] suggested a framework for medical care for epilepsy. This includes, for example, a recommendation for specialist epilepsy clinics and minimum standards for medical attention. However, at present the extent of medical care (primary and hospital care) which epileptic patients actually receive is largely unknown, and until such data is available, planning is difficult.

We are undertaking a survey into the current provision of services for people with epilepsy in order to define how improvements can best be made. The study will take the form of a questionnaire given to patients as they collect repeat prescriptions for anticonvulsant therapy. This will determine aspects such as the frequency of inpatient and outpatient hospital visits.

We would like any general practitioners who would consider participating by distributing questionnaires to contact us, either by writing to Dr S. Shorvon, Chalfont Centre for Epilepsy, Freepost, Chalfont St Peter, Bucks SL9 7BR, or by ringing Dr S. Shorvon or Dr Y. Hart (tel. 02407 3991).

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Reference

1. Department of Health and Social Security. *Report of the working group on services for people with epilepsy: a report to the Department of Health and Social Security, the Department of Education and Science and the Welsh Office.* London: HMSO, 1986 (Chairman PMC Winterton).

Patients' views on preconceptual care

Sir,

Dr Ingamell's letter (November *Journal*, p.510) suggests that few patients attend preconceptual clinics. It is perhaps not surprising if couples feel that their plans for pregnancy are personal and hesitate to visit a preconceptual clinic. But this does not mean that they would not appreciate the offer of a personal preconceptual consultation with their own doctor or a chance to read the Health Education Council's pregnancy book, which was researched and written by Nancy Kholer with the intention that it should be