Diabetes care

Sir,

I read with interest the article by Marek Koperski highlighting the disparity between the cost of diabetic care in hospital and general practice clinics (September *Journal*, p.370). Diabetes is a common disease which often remains undiagnosed.[1] I agree with the author's comments that general practitioners have an important role to play both in the screening of high risk groups and in routine follow up of patients with diabetes mellitus.

Koperski proposes that hospital based diabetic clinics provide a specialist opinion on difficult management problems rather than routine follow up. Patients attending such a specialist clinic would therefore need more frequent appointments and may take longer to be seen at each consultation because of their more complex problems. Hospital clinic costs per patient would therefore inevitably rise as the number of patients seen per clinic decreases.

General practice based clinics are an important and logical step forward in the routine care of patients with diabetes mellitus. However, specialist back up must be available. Any proposals to provide such clinics in general practice should take this into account and funding for such clinics should not be made available by reducing the hospital clinics best able to provide that specialist back up.

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Reference

1. Harris MI, Hadden WC, Knowler WC, Bennett PH. Prevalence of diabetes and impaired glucose tolerance and plasma glucose levels in a US population aged 20–74 years. *Diabetes* 1987; 36: 523-524.

Diploma in geriatric medicine

Sir,

The minutes of the 1991 annual general meeting of the south London faculty of the Royal College of General Practitioners contained the following: 'The south London faculty has been concerned at the development of diplomatosis, defined as interference with the educational experience of the trainee year. Our views that the College exam should be sufficient to fit the general practitioner for all aspects of general practice (and should be changed if this were not so) were strongly represented to council and evoked some sympathy. However, several royal colleges were pressing for these [diplomas] and the College now seemed set on this course. It seemed to be an issue of power and influence within the individual colleges, as much as an educational measure.'

In 1980, only 15 years after its inception, the RCGP membership examination contained a question on the elderly. Log diaries of candidates always reflect lack of contact with older patients. Assessing candidates' attitudes in the oral examination can be deceptive when compared with observing a candidate for the diploma in geriatric medicine communicate with and examine a patient at the bedside. When speaking to trainees I have encountered devastating ignorance of geriatric medicine, owing to inadequate undergraduate teaching, and a low preference for geriatric posts in the trainee hospital year. One trainee, when asked what rearrangements he would suggest for the home of a patient handicapped with parkinsons disease, answered 'I'm not a social worker', a remark greeted with mirthful approval by his colleagues.

Next year will be the European year of older people and solidarity between the generations. The National Health Service and community care act 1990 is due to be introduced in April 1993. While recognizing that some diplomas are now anachronistic, it is clear that the diploma in geriatric medicine has great relevance in an ageing society and is highly valued by those who have taken it.

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The quiet trainee

Sir,

Quiet trainees are often perceived by trainers and course organizers as being problem trainees. They are often described as 'a poor communicator', or as someone who has 'unexpressed problems', or who 'will not cope with the stresses of being a partner in general practice'.

I have observed that the majority of trainers and course organizers are extrovert, talkative communicators and often become anxious about quiet trainees. Perhaps they are in danger of judging a quiet, introvert personality as difficult and a problem, and unlikely to become a good doctor because this is not how they are themselves. In reality, it is often the trainees' quiet, patient, non-anxious personalities that make them good, empathic listeners and excellent doctors in the one to one situation.

I have observed three or four quiet trainees out of the 20 trainees we have had in our training practice. They have all been competent and among the best trainee general practitioners we have had. This is perhaps not surprising when it is considered that the central relationship of general practice is the one to one patient–doctor consultation. I have noticed that the quiet trainees in the practice have often had a strong following from patients with difficult psychological or social problems. Review of the notes has shown that these patients have made many consecutive consultations with the quiet trainees, who often give much support and make much progress with such patients.

I recently shared these thoughts among a small group at a course organizer national conference at Ripon College in July 1992. It was agreed that both the quiet and very noisy trainees were perceived as presenting problems. However, the eventual consensus of the group was that many quiet doctors were well balanced, self-sufficient doctors who often derived benefit from listening to the general group discussion; the extrovert talkers who would not stop talking were felt to be more likely to have the personality or communication problems.

Trainers and course organizers should not necessarily be worried by the quiet trainee. They should check out from patients' notes and colleagues that these doctors are functioning satisfactorily as doctors with patients and if they still feel anxious in spite of satisfactory feedback they should question whether the problem lies within themselves rather than the trainee.

If it is true that the quiet trainee is often an excellent general practitioner, are we selecting enough of these quiet candidates at interview for vocational training? The talkative extrovert is an easier candidate to interview, since the trainee is usually expected to do most of the talking. However, in the consultation, especially in the 10 minute patient-centred consultation, to be a good listener is the greatest asset, and that judged as most important by patients, according to a *Which?* report published in April 1992 entitled 'GPs — your verdict'.

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