LETTERS

Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Systematic care of diabetic patients

Sir,

The systematic care of diabetic patients described by Koperski (December *Journal*, p.508) may lead to 'a significant improvement in care for diabetic patients', but outcome is not guaranteed by recording process measures better or recording a reduction in patients' glycosylated haemoglobin levels. The link between such measures and improved quantity of life coupled with reduced morbidity and less premature mortality remains debatable.[1]

Only 64 diabetic patients (out of 111 known diabetic patients in a practice population of 13 500) were willing and able to attend the diabetic day and eligible for inclusion in the study. Perhaps another 50–100 unknown diabetic patients in the practice did not receive the same systematic care.

Our practice of 13 085 patients is similar in size and commitment to that of Koperski, and has provided systematic care for diabetic patients since 1984. In 1990 three standards were set to audit each year:[2] all patients will be offered a diabetic check-up each year; all patients aged less than 70 years will have their fructosamine concentration measured each year; and in patients aged less than 70 years 90% of patients will have a recorded fructosamine concentration less than 3.5 mmol l^{-1} and 70% will have a recorded fructosamine concentration less than 2.8 mmol l^{-1}. If no fructosamine level was recorded, it was assumed that the standard was not achieved. The results for the years 1990–92 are shown in Table 1.

Our experience has shown that the practice has a high prevalence of diabetes compared with other practices, and that despite our efforts it is difficult to provide systematic care for all patients.

Until the link between type of care and subsequent patient benefit is confirmed, we will continue to use systematic care to achieve our standards. We hope this leads to an improvement in care for all our diabetic patients.

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References

1. Kinmonth A. Diabetic care in general practice [editorial]. *BMJ* 1993; **306**: 599-600.
2. Kemple T, Hayter S. Audit of diabetes in general practice. *BMJ* 1991; **302**: 451-453.

Table 1. Outcomes for patients receiving systematic diabetes care between 1990 and 1992.

	1990	1991	1992
Practice population	13 200	13 286	13 085
No. of diabetic patients (prevalence)	223 (*1.7*)	224 (*1.7*)	234 (*1.8*)
% of diabetic patients checked in past 13 months	*85.7*	*86.6*	*91.0*
No. of diabetic patients aged <70 years	149	144	153
% of patients <70 years with fructosamine level recorded	*75.2*	*77.1*	*81.7*
% of patients <70 years with fructosamine <3.5 mmol l^{-1}	*61.7*	*75.0*	*77.8*
<2.8 mmol l^{-1}	*34.9*	*52.1*	*57.5*

Primary care teams

Sir,

In his editorial on the primary care team (December *Journal*, p.498), Colin Waine pointed out that the differing remuneration of team members can cause resentment. Management research shows that job satisfaction is not particularly related to pay.[1] More important is mutual respect among members of the team and respect by the organization (for example the practice or the health authority) for what each member of the team is contributing.

In the paper on the diagnosis and treatment of asthma in children (December *Journal*, p.501) Neville and colleagues appear to have drawn the wrong conclusion from their results. I feel that the paper demonstrates the need for us to use our records as a diagnostic tool and that we should now be more aware of the importance of certain items of history in making a diagnosis of asthma. Certainly in my practice, with the introduction of computers I can now see details of the last 17 visits on one screen and this should certainly make it easier to diagnose asthma. Three of the five authors of this paper are not medically qualified and they demonstrate that we can gain much from using other resources in preparing our strategies. Implicit in the paper is concern that patients are being undertreated. At a time when we are striving to avoid overtreatment surely the situation is not as parlous as suggested. We should indeed make better use of our records but we should not rush into treating every child without careful appraisal.

The way forward in improving general practice does not lie merely in asking for more money for the staff we now have or for the staff we would like to have. It lies in being better managers of our staff and better educated clinicians.

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Reference

1. Jones RVH. *Working together – learning together. Occasional paper 33.* London: Royal College of General Practitioners, 1986.

Heroin users on a methadone programme

Sir,

The paper by Leaver and colleagues (November *Journal*, p.465) quantifies some of the problems familiar to all general practitioners working in areas where heroin abuse is endemic. However, some of the conclusions drawn by the authors with regard to the costliness of general