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ABCD Newsletter

The Official Bulletin of the Association of British Clinical Diabetologists

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EDITORIAL

I am not a number

Peter Daggett
Editor, ABCD Newsletter

In the village where the prisoner lived, everyone had a number. Patrick McGoohan's character was number 6 and his constant assertion was that he was a man and not a number. I think that is how our patients may sometimes feel. They are told firmly by number 2 (their doctor) that this or that biological variable must be at a certain level. When they ask who has said so, they are told "number 1", but no-one knows who or what number one is. We all suspect it is the government, whose wishes are imposed by benign guardians called rovers (DSNs). If I were a patient, I would object to being managed by numbers and would probably wreak havoc in the clinic by insisting that I be treated as a human being. It is actually rather surprising that so many people do not take such a view and for the number 2s, just as well. Number 1 may in fact be a computer and of course, computers love numbers.

In the United States, a substantial proportion of the population know their "cholesterol number", even if it is expressed in anti-diluvian units. That has led to an obsession with healthy food and a bonanza for the statin manufacturers. The UK is going the same way, but since our population are not notably healthy eaters, they just take the drugs. At least they say that they do. I have heard several diabetic patients comment recently that they hadn't realised that they felt groggy until they ran out of their statin and had to stop them until they could get a new supply. We all know that statins and fibrates can cause myalgia, but I wonder if the time has come for an audit of well being on these drugs.

UKPDS taught us the importance of tight blood pressure control. Almost everyone is agreed that individuals with diabetes should have a systolic

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pressure below 130, but there is still some confusion about the diastolic. Most patients and a lot of GPs however, are more concerned about the diastolic, but there is a suggestion that lowering this leads to a widened pulse pressure and it is that which damages the circulation. Blind adherence to a pre-ordained pressure is probably unwise. Younger patients can tolerate low systolics, but older ones can't and over the age of about 70, people usually feel ill. We all see patients falling over because of postural hypotension consequent upon multiple drug usage. We can tell the patient sitting in front of us in the clinic that low BP is good for them and in the case of type 2s, we can call up the UKPDS risk engine to show just how effective is lowering of BP in preventing vascular mayhem. It is more difficult to do that in the orthopaedic ward. There you find an old man with a broken hip caused by a postural fall, who told you the week before that he felt ill when his BP was too low, but who you had assured was fine with a level of 125/80.

Finally, haemoglobin A1c. We all know that this needs to be as low as possible, but that also means as low as is feasible. In pregnancy, where the patient is maximally motivated and the doctor is maximally enthused, levels below 7% can usually be achieved. This requires an enormous investment in time by the patient and effort from everyone in the diabetic clinic, but the end of course justifies the means. Many patients cannot however achieve such good results and although they feel perfectly well, they are often embarrassed by what they see as their failure. By being judgmental about a number, we encourage defaults, which make things worse. The practice of winding up the dose of sulphonylurea or insulin until the patient has the right number, simply leads to hypoglycaemia or weight gain and that is often not justified. When the person sitting in front of us feels really well, has minimal complications and produces a book containing near perfect blood glucose results, I would suggest that we should accept that. The HbA1c seems have become imbued with almost mystical properties, at least in the eyes of the Department of Health. This dogma is upsetting for many people and blind pursuit of it can be frankly dangerous.

By now, you will have noticed that I am confused. I have written a piece extolling the virtues of the Joint British Societies recommendations[1], but now find myself calling some of them into question. I doubt however if I am alone. One of the things that GPs do well is to listen to their patients. Specialists may not do, because we think that we know better. Often we do, but number 6 distrusted number 2 because he never accepted anything that he was told. Our patients are not numbers and if they are going to trust us, we should remember that.

Reference

1. Daggett, P Achieving the new Joint British Societies 2(JBS 2) targets - or not. *Practical Diabetes Int* 2006; **23**(7): 280-281

AACs IN YEAR TO APRIL 2007

In the year ending April 2007, there were 31 AACs in our specialty, one of which was in Northern Ireland and one in the Armed Forces. 15 of the AACs were for newly created positions, 6 for retirements and 10 to fill long term vacancies. Of the 31, 1 was purely in endocrinology and 1 purely in diabetes. In 3 cases, no appointment was made.

There are no data on the number of applicants for each post. We have previously expressed our concern though, that there had not been enough applicants for posts and it is possible that failure to appoint resulted from that. My recent experience at AACs suggests that the situation is now very different and there are many appointable applicants for each post advertised. Given the increasing incidence and prevalence of diabetes, it is worrying that so few posts in our specialty are being advertised. It is an indication of the desire of the government to promote community care for diabetics. This has occurred just as the bulge of SpRs reach their CCST and the disparity needs to addressed urgently.

I am most grateful to Linda Counter at the Royal College of Physicians for providing the raw data.

ABCD Autumn meeting 2007

November 1-2 2007
Hotel Russell, London

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CONTRIBUTE TO YOUR ABCD WEBSITE!

www.diabetologists.org.uk

Keep an eye on the notice board for the latest information. Powerpoint presentations from recent ABCD meetings can be downloaded from the members only, password protected, website. Any member can easily use the Sharepoint technology underpinning this area of the website to set up nationwide audits. There are ongoing discussions that we invite you to contribute to and new discussions can be easily be set up. ABCD website officer, Bob Ryder, can supply user name and password for the members only website and also advise on the above.
Tel No: 0121 507 4591 Email: ryder@diabetologists.org.uka

What will we do when the money runs out?

In this article Dr John Wales thinks aloud about what might happen if the financial state of the country deteriorates to such an extent that money for public services - including the NHS - falls significantly. Without doubt the care of patients with chronic medical conditions, such as diabetes, would be affected. He suggests some ways in which diabetic patient care might then be reorganised. You may think that such a thing would never happen, or that we are really powerless to alter what would happen in a future "slimmed down" NHS. Why not write to the Editor of the ABCD Newsletter with your observations, suggestions or ideas as to what might be done if the NHS money does run out for diabetes care and whether alternative ways of funding have to be explored?

Over the past few years there appears to have been a political rethink about the funding of the NHS. While few politicians would state in public that the country cannot afford the universal NHS that was envisaged in 1948, there are signs which suggest that we are approaching the acceptable limit of spending on the NHS. They include escalating prescription charges, restriction on certain types of surgery, inadequate NHS dental care, the creation of NICE and the questioning of treatment for patients with so called life style conditions. It seems clear that to maintain a universal NHS, the percentage of the UK's GNP spent on it must be increased significantly. Such an increase is unlikely to occur, particularly if there is an economic downturn. That may happen as a result of global warming, a UK energy deficit, civil unrest, or lesser potential catastrophes, such as another NHS IT failure, a Millennium Dome, another invasion, or even the Olympics. If there were a major financial downturn in the UK and therefore in the NHS, how might this affect diabetes? It is relatively expensive and its prevalence is increasing. Affected individuals live for many years and need long term treatment.

The pattern of costs for diabetes can be divided into two phases.

- The first aims to prolong life and prevent complications for both type 1 and type 2 diabetic patients. It includes such things as glycaemic monitoring, insulin therapy, use of hypoglycaemic drugs, lipid and BP control, foot and retinal screening. The need for these may last for many years.
- The second starts when significant complications have occurred and includes management of renal failure, coronary heart disease, restricted sight and arterial disease. These have large financial and social costs to the patient and the state.

The present NHS philosophy seems to be that these two phases can be dealt with separately — the first phase by general practitioners and the second by specialist physicians. If however GPs elect to do more themselves, funding for specialist care will be reduced to a level where hospital based diabetes care in the NHS is not viable, leading to loss of expertise. The two phase system of care would become unsustainable if financial constraints were imposed and that would result in two problems. On the one hand, there would not be enough specialists who might be able to control costs, while on the other there would be GPs who do not wish to take on specialist care. They might however find that they have no specialist to whom they can send their patients. As overall diabetes patient care deteriorated, the total costs would increase, but a cynic might actually think that if diabetes related mortality increased as a consequence, the costs of long term care could be partly recouped!

What might happen to diabetes care if there were a major squeeze on NHS funding by central government? This might be sudden if there were a major financial collapse, but is more likely to be by smaller than inflation increases in funding. Savings might be sought through the drug bill, including insistence on only generic drug prescribing, more pressure from NICE to limit the introduction of new drugs and by limiting free medication for diabetic patients to drugs needed for their diabetes and the prevention of complications. Just as worryingly, there might be lengthening of the suggested time between retinal and foot screening or restricting the availability of treatment for major complications such as coronary artery surgery, renal replacement therapies and sophisticated foot surgery. The government might make a conscious decision only to fund diabetes care partially, i.e. only acute diabetic problems or major complications such as renal failure. In the extreme the decision might be not to fund it at all because the tax bill could not be sustained by the general population in difficult financial circumstances. The shortfall on the care bill would have to come from somewhere else — almost certainly the patient.

The government could seek payment for care, eg higher prescription charges or payment for specialist as against primary care. One would anticipate such strictures would apply to all chronic conditions. Some patients might well seek private diabetes care outside the NHS but I would anticipate that the numbers would be limited by the long term expense involved. However if private health care costs for diabetes became tax deductible, patient numbers would increase as it became worthwhile for providers to devise long term care packages including second phase treatment. Even so it is likely to be a route which only the middle and upper classes would consider. I would hope though, that the NHS would decide what it can afford to spend on diabetes care as a whole and then seek providers of that care within the cost limit. It would seem unlikely that primary care would be able to provide both phases of diabetes care. Most diabetologists on the other hand, can and do provide this and could offer to provide a total diabetic care service. The diabetologist could organise the whole diabetes care package to a large population and employ or contract specialist nurses, dieticians, chiropodists, retinal screeners on a sessional basis. Other specialists such as ophthalmologists, renal physicians, vascular surgeons and cardiologists could be hired in a similar way. In-patient care would be purchased from hospitals either private or NHS. Groups of diabetologists could work together to deliver care for a large area — a city, or even county. The drivers of care would be the specialist physicians providing the best management — as well as giving value for money . One might well argue that this is the way diabetes care should have developed over the past few years and there are signs that others are thinking along the same lines with surgical chambers and the like. The affordability of payment by patients for all chronic medical services and value for money becomes important for all individual patients. A difficulty always arises for any health care provider that includes the disadvantaged in society. A safety net of financial support from National Insurance contributions would be needed for these diabetic patients or even a hypothecated tax.

To those of us who have grown up with the concept of the original NHS, such thoughts are depressing. However, it is important that we think and discuss what we as physicians would do if national circumstances resulted in a marked economic

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downturn and funding for health care as well as other central services became reduced. We don't want merely to react to such a disaster but should have some plans as to how we might try to give as good care as possible to all our diabetic patients. I have every confidence that if faced with such changes, my colleagues in ABCD would be better placed to provide an effective, equitable and economic diabetic care plan for the country as a whole than the Department of Health, driven as it is by its political masters whose contact with reality seems tenuous at the best. What do you think?

Spring 2007 Meeting of the Association of British Clinical Diabetologists

Highlights of the Spring 2007 ABCD Meeting held at Crowne Plaza Chester, Chester, on 16/17 May 2007.

2006 Diabetes UK Survey of Consultant Diabetologists in England

Ken McLeod *(Exeter)* introduced his talk by paying tribute to Sue Roberts *(National Clinical Director for Diabetes)* for her continued efforts on behalf of diabetes care, and then ran through the findings of a survey of the roles, responsibilities and job satisfaction of consultant diabetologists in England, carried out by Diabetes UK last year. As revealed by the survey, the views of consultant diabetologists were that: They were clinically skilled at managing a complex chronic disease, had special relationships with patients and had long years of training and experience. They were the natural leaders of the diabetes service, who could and should set priorities and direction and be responsible for service development. They had a key educational role with patients, multidisciplinary staff, primary and secondary care diabetes teams and other non-diabetes secondary care health professionals. They were ultimately responsible for the quality of diabetes care of not only their own patients but of all diabetes patients in the health care community.

Joint ABCD–Diabetes UK Specialist Service Consultant Survey

Peter Winocour *(Hertfordshire)* then presented the preliminary results of the recently completed joint web-based ABCD–Diabetes UK Specialist Service Consultant Survey. He concluded from the data that there was a need for a national commitment to fund more consultant posts in general medicine-diabetes or diabetes alone, with a range of roles for the diabetes service from a pool of consultants. Above all, there was a need for a publicity drive and political lobbying to emphasise the desire of specialist diabetologists to engage in the development of new service models. The support of the National Clinical Director for Diabetes in this was essential.

The ABCD Debate. This house believes that inhaled insulin is an expensive waste of breath

Chair: Alan Rees (Cardiff)

For the motion

Ian Gallen (Buckinghamshire)

Proposing the motion, Ian Gallen said that at present there was only one licensed inhaled insulin, Exubera from Pfizer. Dr Gallen conceded that Exubera did work, just, but said it was very expensive, with running costs of between £800 and £2300 *pa*. Behind the concept of inhaled insulin lay two hypotheses: (1) that fear of injection delayed new or intensified insulin administration; and (2) that people in general would prefer not to inject.

In fact, anticipated pain was only one factor in the resistance to insulin. The DAWN survey showed that there was a considerable physician element in the resistance and that 50% of patients did not think insulin worked. Others found that 50% of patients thought that initiation of insulin therapy meant their diabetes had become more serious and 50% thought it indicated a personal failure. Admittedly, patients said they would be prepared to increase their use of insulin if it was available in inhaled form. He had organised education sessions for 150 patients in High Wycombe who had expressed interest in inhaled insulin. After three sessions, only eight signed up for it and of those only two followed through – and even they stopped!

Could one manage on inhaled insulin without basal insulin? Yes, but there were problems. Inhaled insulin would not work in those with overnight glucose problems. If inhaled insulin improved quality of life, it was only by a very small amount. There was poor evidence that inhaled insulin led to an increase in insulin treatment in insulin rejectors. There was evidence of changes in lung function in people with type 1 diabetes, following administration of inhaled insulin. In addition, it was contra-indicated in smokers. In fact, the proportion of patients suitable for inhaled insulin was quite small – about 40% after five years. From that another 5% had to be deducted for active sportsmen.

Against the motion

Stephen Gough (Selly Oak Hospital, Birmingham)

Opposing the motion, Stephen Gough said that inhaled insulin should be regarded as another therapeutic option, which would allow some patients to improve glycaemic control, thereby reducing complications. It provided an alternative to injection for those with needle aversion or phobia or with injection site problems. Twenty-five percent of patients delayed going onto insulin for five years. It helped those with psychological insulin resistance. There was good evidence of patient preference and patient satisfaction. So far as costs were concerned, those from the complications of diabetes were much greater than those from treatment – probably £3.851 billion a year. Inhaled insulin was an example of an improvement in technology. Using the utility gains assessment method, Exubera produced a utility gain of 0.02–0.04 which equated to a range of £10 000–24 000. According to NICE, a score of £20 000 or less meant that a treatment was definitely cost-effective.

- The vote before the debate was 60 for and 17 against (with two abstentions). The final vote was 49 for and 25 against, with no (declared) abstentions.

Report by James Wroe, Practical Diabetes International

Other presentations at the Spring meeting

- Dr Raj Khattar *(Consultant Cardiologist, Manchester Heart Centre):* Non-invasive assessment of CHD and its role in silent CHD in diabetes
- Professor Brian Frier *(Professor of Diabetes, Edinburgh Royal Infirmary):* Update on driving and diabetes
- Dr Andy Keen *(Clinical Psychologist, Aberdeen Royal Infirmary):* Psychology support in adult diabetes care—A luxury or a necessity
- **Political slot.** Professor David Barnett *(Professor of Clinical Pharmacology, University of Leicester Medical School):* ABCD and NICE
- **ABCD Specialist Registrar Award 2006.** Dr Varadarajan Baskar *(Senior Registrar in Diabetes and Endocrinology, West Midlands):* Classification of renal disease status using estimated glomerular filtration rate in diabetes
- **Hot Topic: invited overseas speaker.** Professor Michael Nauck *(Professor of Medicine):* Gliptins and incretins

CONTROVERSY

General Medicine and on calls..... should I complain?

Partha Kar, Queen Alexandra Hospital, Portsmouth

It's been about 3 months since I came back to the realms of general medicine and on calls after having finished my research. While I have been away the debate about the role of diabetologists in general medicine has continued. Arguments have ranged from the defensive "it's a protective shield against acute trusts ditching diabetes specialists" to the holistic "we are the only specialists who are actually general physicians".

So far, my experience back in the real world could be described as interesting at best and jaw gnashingly frustrating at worst. Let's face it, a stint on a general medicine firm isn't quite what a Foundation trainee looks forward to, nor for that matter any junior doctor. The actual fun of general medicine is minimal, with most of the diagnostic procedures having been taken over by specialist teams. The learning experience seems to have gone, replaced by ward rounds on numerous patients who are awaiting funding to go somewhere, or are suffering from dementia. A few years back, general medicine used to start from the point of admission. As an SHO, we used to clerk our patients, manage them, carry out their practical procedures and learn from them. We then looked after them when they were better and had nowhere to go until their funding came along. The social services set-up hasn't changed much, but what has, is the conversion of the old general medicine into the sexier acute medicine.

When an acute physician asks me what my experience is in their specialty, I am tempted to remind them of my work as an SHO or during my first few years as an SpR, when acute medical units didn't exist. Does that count?

I don't know about the rest of the readers, but the next time, I see a diagnosis of "collapse? Cause" or a management plan which says "Bloods/ Chest X-ray / SpR review", I am sure I will lose my temper. If an audit were done of admission diagnoses, something like this would head the list. We must tell our colleagues forcefully that it is necessary to give a differential. Somebody also please tell these guys that "SpR review" isn't a management plan. I look at cardiology trainees nowadays and I don't know whether to envy them or not. No problems regarding a definition of their roles in an acute trust, no problems in doing their specialty training, not involved in the on call rota, no general medicine commitment. I feel a sulk coming on! So after that rant, is it really all that bad? Actually, it isn't. I love the feeling of being in a team, of doing a ward round together, sitting down for a coffee and the banter amongst colleagues. And then again, you come across patients who may not be acutely sick, but could do with some time and a chat, which is what proper doctors should be doing. Finally, there are those patients with multiple medical problems, and unexplained symptoms where you pick up something others haven't, followed of course by half a day of feeling really good about yourself. I just wish the good old days of general medicine, which I genuinely enjoyed, were still around. At least that way, one wouldn't have to look for scraps to enjoy on the ward, but actually love doing what we are being accredited to do. The problem lies in the way it's all been designed and how the old institution of general medicine has been chopped up, with different specialities doing their own cherry picking. Juniors don't enjoy their time on a designated general medicine firm, but this issue is something, which trusts have tended to ignore. It is accepted that the Cardiologists and Gastroenterologists have their own specialty patients on their wards and that they turn up their nose at the mention of general medicine, but what about the majority of the patients who come through the door and have purely got social problems? What about the ones who are farmed out to medicine because the surgeons or orthopods don't deem them operable and therefore, interesting?

These patients are not in a minority and someone has to do it. Acute medical units don't deal with them, once they have moved off their patch. So, apart from Elderly Care and us "sugar-boys", who else is there? Perhaps the realisation needs to dawn that diabetologists are not just "non-procedural specialists", but also fulfil multiple other roles like looking after general medicine, having endocrine commitments, management roles. Problem is, who is listening?

ABCD-DIABETES UK SURVEY OF SPECIALIST DIABETES SERVICES -2006

ABCD and DUK jointly have recently completed a survey of diabetes services in the UK. It reflects the changes since the original survey in 2000. While improvements in some areas have been noted, for many aspects of care time has stood still. Changes in service models and government policy have conspired to hinder efforts to develop integrated services. At the same time, a continued disparity between specialist services exists in different parts of the country. Key points include:

- In 10% of districts there is still only a single consultant diabetologist
- Consultant Diabetologists spend as much time dealing with acute general medicine as with diabetes and only 25% currently provide community diabetes services
- Only 16% of Consultants have been engaged fully with commissioning diabetes services
- 90% of districts have reduced the size of their hospital based diabetes teams, in particular diabetes nurse specialists.
- There is virtually no provision anywhere for psychological problems, despite there being general agreement that these are common
- In only 26% of the districts surveyed is there a diabetes specialist team judged to be adequate by modern standards

Some of the more worrying comments came from the most experienced clinicians and included:

"Secondary care is being asset stripped"
"Having built the service up over 20 years, there is now a serious threat to DSNs, podiatry and dietician input"
"Our senior diabetes physician will not be replaced on retirement"

These few lines give a flavour of the report, which is now available on the ABCD web site. This has involved a terrific amount of work, which has been carried out by a joint working party with Diabetes UK. The survey has been co-ordinated by our secretary Peter Winocour, supported by Chris Walton, and Dinesh Nagi from ABCD.

FUTURE MEETINGS

The autumn meeting of ABCD will take place at the Hotel Russell in London on November 1st and 2nd. Booking forms and further details are available on the ABCD web-site. This meeting will be followed on November 3rd by the SpR's meeting.

There will be a joint meeting with the RSM on February 27th on "Diabetes and Endocrine aspects of old age".

The spring meeting of ABCD will be held in Harrogate on April 10th and 11th 2008, following the BES meeting.

Peter Winocour
Hon Secretary of ABCD

Chairman's Report

Our Spring Meeting in Chester did indeed provide a much needed opportunity for us to convene and discuss the issues of the day affecting our speciality. Rather like Charles Darwin and his observations on the Galapagos Islands, I have often thought in this way of our separate Diabetes Centres developing their individual initiatives and innovations, whilst delivering an impressive record of progressive improvement in Diabetes Care for our patients. A fundamental principle established by ABCD at its inception was that we would share our experiences, support our colleagues and strive to ensure we worked together and not in isolation. But, extending the evolutionary analogy, are we presently subject to the principle of "Survival of the Fittest"? It does seem like that at times. As specialist diabetologists we do have substantial experience and expertise that I feel is essential for the future of diabetes services in the United Kingdom. Finding a constructive way forward is our immediate challenge. Preliminary results from the recent Specialist Diabetes Services Survey were presented by our Hon Secretary at Chester. A number of positive findings were reported including evidence of less single-handed consultants, more specialist nurse provision (although that may well have since changed) and more sub-speciality clinics being established. On the other hand concerns that specialist services were under threat proved a constant and worrying theme. An advance summary of the survey findings has been circulated, and once the final paper is available, a Press Release is planned with the intention of highlighting the key findings and the implications on patient care.

ABCD continues to be involved in a number of joint initiatives working with the Society for Endocrinology, Diabetes UK and the Royal College of Physicians. Of interest is the proposal by the Federation of Royal Colleges to introduce a speciality higher diploma i.e. MRCP (Diabetes and Endocrinology) which will supplement but not replace MRCP (UK). I am grateful to those ABCD members who have volunteered to be trained in the art of defining discriminant questions and to then determining a repository of 1200 questions for future twice-yearly examination purposes. Older ABCD members will be relieved to know there is no immediate intention to implement retrospective examination!

Inviting the Chair of the Primary Care Diabetes Society to speak at our Autumn Meeting, inevitably involved a "pay-back" requirement. Last month I entered the "Lions' Den" and spoke at the first national GPSI (Diabetes) Conference in Birmingham. Fears rapidly subsided. In fact, a high degree of concordance was evident, all agreeing that we shared common aspirations and that we should talk together more often. I came away feeling that as specialists we are still very much wanted (at least by GPSIs). We resolved that we would continue dialogue and in the first instance would publish a revamped joint position statement on integrated care.

On a final note, could I express my great thanks to Peter Daggett for his Editorship of these regular newsletters, which have been significantly informative and equally entertaining, blended with his own inimitable style. Sadly Peter has indicated that he would like to "stand down" in the latter part of 2008 and we hope that we have found a successor, whose name will be announced at the next ABCD conference.

Ken Shaw
Hon Chairman ABCD

MEMBERSHIP APPLICATION FORM FOR ABCD

Membership of ABCD is open to all Consultant Physicians with an interest in diabetes patient care in the NHS and all SpRs in Diabetes and Endocrinology. At present, the annual membership fee is £50.00. If you are interested in joining the Association, please fill in the application form below and return it to the ABCD Membership Secretariat at the following address:

Elise Harvey
ABCD Secretariat
Gusto Events Ltd
PO Box 2927
Malmesbury
SN16 0WZ
Tel: 07970 606962
email: elise@gustoevents.com

When your application has been approved, you will be sent a Standing Order Form for your annual subscription.

Membership Proposal Form

I wish to apply for membership of the Association of British Clinical Diabetologists.

Please use block capitals

Name (in full, please)

Professional Qualifications

Position held

Address

/ Post Code

Tel. No.

Fax No.

Email

Signed

Date