BRITISH MEDICAL JOURNAL

SATURDAY 13 OCTOBER 1984

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SUPPLEMENT

NO 6450 BRITISH MEDICAL JOURNAL 1984 VOLUME 289 937-1020 WEEKLY. ISSN 0007-1447
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR. ASTM CODEN: BMJOAE 289 (6450) 937-1020 (1984)

CORRESPONDENCE

We may shorten letters to the editor unless the authors specifically state that we may not. This is so that we can offer our readers as wide a selection of letters as possible. We receive so many letters each week that we have to omit some of them. Letters must be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Diabetes care: whose responsibility?

SIR,—A rapid reading of the two recent articles evaluating general practitioner care of type II diabetics might perplex some general practitioners who are reconsidering the care they provide (22 September, p 726 and 728). Comparison of process and outcome measures in patients looked after in general practice with similar patients retained in the hospital diabetic clinic highlights the following points:

(1) Routine general practitioner care, where no special mechanisms are employed to ensure regular follow up and review, appeared to increase the risk of poorer diabetic control and higher overall morbidity and mortality. In the Cardiff trial only 13·6% of patients discharged to general practitioner care from the hospital clinic were seen once a year, and of these only one third had a blood glucose estimation taken in the same period.

(2) In the Wolverhampton study (p 726), well organised care by interested and committed general practitioners (as indicated by the running of miniclinics) resulted in a similar degree of diabetic control to that achieved in a hospital clinic, as judged by retrospective mean blood glucose and glycosylated haemoglobin concentrations or prospective glycosylated haemoglobin concentrations.

Several other studies provide relevant information about current patterns of diabetic care, which we feel add weight to these findings. They also have implications for those of us who are trying to develop a strategy for the community care of these patients.

In 1980 one of us reported on the current patterns of care in an east London health district.[1] Of 217 diabetic patients attending nine general practitioners in three group practices (without miniclinics) 54% were not currently attending a hospital diabetic clinic. The frequency of clinical review was substantially lower in these patients than in those attending the hospital clinic, although there was no significant difference in glycosylated haemoglobin concentrations.

Other studies in various parts of the British Isles have also shown that between 45% and 54% of diabetic patients do not regularly attend a hospital diabetic clinic and may not visit their general practitioner for regular supervision.[2–4] It would appear therefore that only about half of known diabetics receive routine general practitioner care even in districts with diabetic hospital clinics. We must assume the figure to be higher in those 28 districts the British Diabetic Association has recently identified as having no consultant with responsibility for diabetic care (unpublished report to the medical advisory committee of the BDA, 1983).

Together the two *BMJ* papers give us some measure of the avoidable morbidity and mortality that might follow for diabetics if their care could be better organised and their follow up ensured. Yet only 37% of patients in Wolverhampton attend practices where a general practitioner runs a miniclinic even after 14 years of encouragement and support from the consultant and hospital clinic.[5] It is unlikely that a global policy of encouraging general practitioners to set up diabetic miniclinics—particularly in inner cities—will both provide a solution to improving diabetic supervision by general practitioners and at the same time reduce the number of patients attending overcrowded hospital clinics. In any case there are strong reasons to believe that a miniclinic mentality in general practice towards every chronic disease with an appreciable prevalence is both impractical and undesirable.

In Islington we are encouraging a flexible approach to general practice diabetic care. Some practices have set up miniclinics, others are seeing diabetics in normal surgery time, while another proposes a "diabetic day" during which diabetic patients will be booked in to see their own general practitioner and the practice will be geared up (though not exclusively) for diabetic measurements. Yet another proposes a weekly "diabetes hour" alternating between partners during a morning surgery. All these practices have been provided with specially designed 10 year record cards which fit in the general practitioner notes or can be held by the patient.

In neither the Cardiff study nor the Fife study before it, however (unpublished report by A M D Porter of the Kirkcaldy Community Medical Care Project, 1979), did such a record card prove a failsafe device to ensure regular or relevant clinical review. For this reason we are looking at the possibility of creating a district diabetic register and using a centralised computer prompt to both patient and general