*ABC of Diabetes*P A THORN
PETER J WATKINS

ORGANISATION OF DIABETIC CARE

Care of diabetics requires enthusiasm and organisation. There are different ways of undertaking it, but without interest and motivation none will succeed.

It is best to bring diabetics together into properly organised clinics, whether in general practice or in hospital, so that they can benefit from the wide range of special services needed for their proper care. Ideally, uncomplicated diabetics should be cared for in general practice diabetic clinics staffed by trained staff working in close liaison with the diabetic physician at the local hospital and the staff of the diabetic clinic; there should be regular meetings to maintain interest and standards.

Special records are required to document progress, treatment, and complications; they should include a problem sheet placed where it is easily seen.

The diabetic health visitor—The most important innovation in diabetic care during the past two decades has been the introduction of a health visitor with special interest and training in the care of diabetics. An enthusiastic health visitor or nurse transforms the standard of diabetic care, achieving liaison between hospital, general practice, and patients at home and offering a wide range of educational expertise. No clinic of any size should be without a health visitor or nurse with this role, and very large clinics will need more than one. The recent introduction of certification in diabetes by the Joint Board of Clinical Nursing Studies should prove important in improving nursing standards in this specialty.

Hospital diabetic clinic

Apart from the medical and nursing staff and specially trained health visitors or district nurses, several special services should be provided by hospital clinics. They should include a *dietetic service*; a *foot service* for treating and preventing foot problems; and an *eye service*. The foot service should include a chiropodist, an orthopaedic surgeon, and a shoe fitter. The eye service should provide facilities in the clinic for testing visual acuity, and there should be close liaison between the staff of the clinic and an ophthalmologist.

Pregnancy service—Antenatal clinics for pregnant diabetics are ideally conducted by the diabetic physician and an individual obstetrician.

Care of children and adolescents is ideally undertaken in clinics separate from the routine adult clinics, where there is close liaison with paediatricians. Care in specialist clinics rather than routine outpatient clinics is just as important for children as for adults.

Educational service—The whole diabetic clinic provides both treatment and education for diabetics. The most important aspect of this education is the medical consultation between the individual patient and the physician, but help from the health visitor in educating individuals is essential. Other forms of education (classes, seminars, audiovisual aids) are also useful and will obviously vary according to local needs and interests. Videotapes should prove invaluable in teaching diabetics, and the British Diabetic Association now has a comprehensive series.

Diabetetic kitchen, King's College Hospital, 1935.

Records

Right and facing page: Inside and front sheet of general practice diabetic record. *Below left:* Problem sheet in diabetic clinic records. *Below right:* Check list for teaching patients about various aspects of their condition.

<u>Initial examination</u>		<u>CNS</u>		<u>R</u> <u>L</u>		<u>Feet</u>
<u>CVS</u>		Knee				<u>Chest x-ray</u>
B P		Ankle				<u>Other investigations</u>
Femoral		Plantar				
D P		Pain				
P T		Vibration		V A (R) (L)		
		<u>EYES</u>				
		Lens				
		Retina				
<u>Important notes</u>						
Date	Weight	Urine GKA	BS	VA R L	BP	Treatment
						Next visit

DIABETIC DEPARTMENT		Unit No 076542
PROBLEM SHEET		Surname CASABON
		First Names Dorothea
		Date of Birth 01/09/36
<u>ALWAYS INCLUDE DATES</u>		
Family history	Mother Sister	Date of diagnosis 1945
Retinal examinations	1945 1951 1955 1958 1960 1962 1963 1964 1965	
	0 0 0 a few some + Peripheral Disc NV(R) R-blind	
	Mas dotst soft Exudates NV laser treat- L-laser treatment	
Renal complications	1960 1964	
	intermittent continuous proteinuria proteinuria	
Neurological disorders	1963	
	neuropathic foot ulcer	
Diabetic coma	1946	
Diabetic pregnancy	1957: ♀ BW 4.2kg 1959: SB at 36/52, 1961: ♂ BW 3.5kg	
B.P.	1945 1955 1960 1962	
	100/60 110/65 120/65	
Investigations of interest	1964 Creatinine 180 μmol/l	
Other diseases	1951	
	Addison's disease on cortisone 37.5 mg/day	
Patient's address	G P's name Lydgate	
	Address	

<u>Teaching checklist</u>	
1 Explanation of diabetes	15.2.82
2 Administration of insulin	15.2.82
(a) Equipment	
(b) Technique	
3 Understanding hypoglycaemia	15.2.82 Not Sure he understands
4 Understanding diet and conversion of portions to fluids	15.2.82 Hopeless
5 Seeking medical aid in illness (STRESS IMPORTANCE OF NEVER OMITTING INSULIN)	15.2.82 And given
6 Urine analysis	15.2.82 Clin test
7 Feet	15.2.82

The diabetic clinic in general practice: Wolverhampton scheme

Name	NHS No
Address	Hospital No
	Age Date of Birth
Occupation	MF MSW
Date	FAMILY HISTORY
Evidence for diagnosis	
Year Age	
Clinical State	HKWkg PRESENT WTkg HEIGHTcms STANDARD WTkg RELATION OF PRESENT WT TO STANDARD WT%ABOVE%BELOW
Treatment Policy	USUAL DIET SUGAR BREAD CHO

Elliott P Joslin, 1869-1962.

Patients find clinics in general practice most agreeable, and follow-up of non-attenders is much more effective in these clinics. The needs are similar to those in hospital but obviously very specialised forms of care cannot be given. Ideally, the health visitor should attend practice clinics; and there should be some arrangements for foot care and chiropody, dietetic advice, and facilities for testing visual acuity.

Practices in Wolverhampton and surrounding districts have 10 years' experience of running general practice diabetic clinics. There are six essentials if these are to be successful. Firstly, at least one member of the practice must be interested in diabetes and the whole practice must agree that a regular diabetic clinic session is desirable. In some practices more than one partner has become active in running a clinic. Secondly, one or more practice nurses or health visitors should become concerned with diabetic patients; once involved their interest and knowledge will grow. The nurse or health visitor should share the responsibility for the patient's diabetic education and may monitor blood pressure, feet, and visual acuity. Thirdly, a special record card for diabetes is essential. This includes presenting symptoms, evidence for diagnosis, and columns for weight, urine tests, and blood glucose. There is also space for clinical notes and information about complications and treatment. Fourthly, the practitioner should become competent at ophthalmoscopy or make other arrangements for monitoring of eyes, possibly with ophthalmic opticians or with the hospital diabetic clinic. Fifthly, a system for regular review must be developed; in our area each practice has its own system. Finally, close liaison with the diabetic consultant should be maintained. Nearly all the patients attend hospital once at diagnosis, when their treatment can be discussed. Thereafter about 75% of patients are looked after in the practice. All children, adolescents, and many young adults continue to attend the hospital clinic on a long-term basis. Patients whose diabetes becomes difficult or who develop complications may well return to the hospital clinic either temporarily or permanently. All patients return to the hospital clinic for their pregnancy. Six evening meetings a year are held in the local medical centre, often with visiting speakers; both doctors and nurses from the practice's miniclincs attend, and the attendance is excellent.

Once accustomed to the idea of attending a general practice clinic the patients much prefer attending them than the hospital clinic; the defaulting rate is much lower. Once a practice starts in the scheme enthusiasm grows and so far no practice has withdrawn. As a result a good working knowledge of, and interest in, diabetes has increased vastly. Co-operation from the consultant in clinical chemistry is invaluable. Nevertheless, the facility of having an immediate blood glucose result available in the surgery or in the home may by itself avoid the need for hospital admission.

In practices which do not have a miniclinic diabetics tend to see their doctor only when they have symptoms: they tend not to get weighed, not to have their blood glucose concentration measured, and not to get monitored for complications. The defaulting rate under these circumstances is high, and the patients usually get back to the hospital eventually with either grossly uncontrolled diabetes or complications in the feet or eyes that need urgent attention. Effective diabetic care in general practice seems to have to be organised or it will not take place.

Other schemes have been described for care of diabetics such as the co-operation scheme in Poole, or the use of a hospital team to help general practitioners with their clinics. Different geographical areas will have different needs, but any doctor who undertakes the care of diabetics must heed the words of the late Dr Elliott P Joslin: "To retain his patient for 20 years he must shun proprietary remedies as the devil does holy water, continually seek for new knowledge as eagerly as the diabetic grasps for life, but ever sift the wheat from chaff remembering that faithful treatment in season and out of season is rewarded."

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