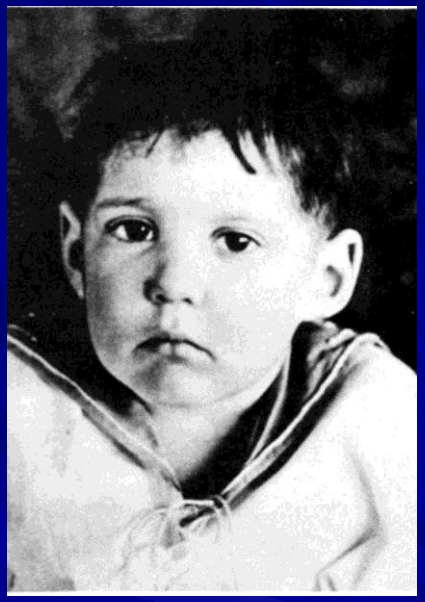
This house believes that Community Diabetologists have little part to play in the management of diabetes

Scope of the debate

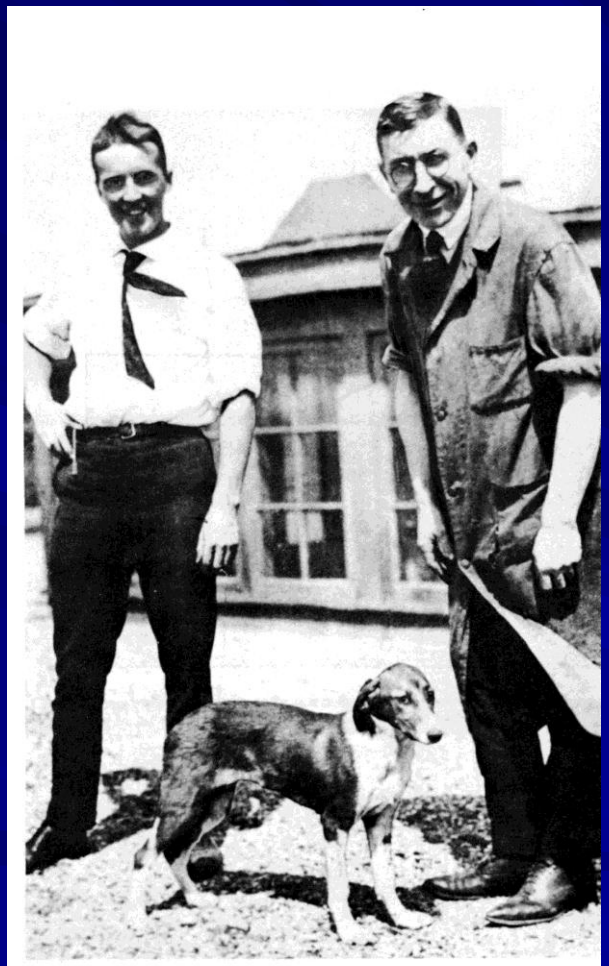
- That Consultants in diabetes should not work in the community ?
- That there should be no such specialty as ‘Community Diabetes’
- (that there should be no such specialty as ‘Hospital Diabetes’)

Treatment of Diabetes



In the days before insulin, children were brought to hospital in an attempt to save their lives. In this way, the specialty of diabetes found a root in the hospital sector.

A ‘procedure’ for diabetes



Besting, Banting and a dog on the roof of the Medical Building. Thought to be in the summer of 1921, but dated April 1922 by Banting in his scrapbook.

The hospital basis of diabetes was reinforced through the scarcity and novelty of insulin

The ‘hospitalisation’ of diabetes

In the UK, the cause was taken up with the formation of the British Diabetes Association

The Traditional Diabetes Clinic

Everybody with diabetes was sent to hospital, spawning huge diabetes clinics :

Is this good care ?

Community Diabetes : an inauspicious start.

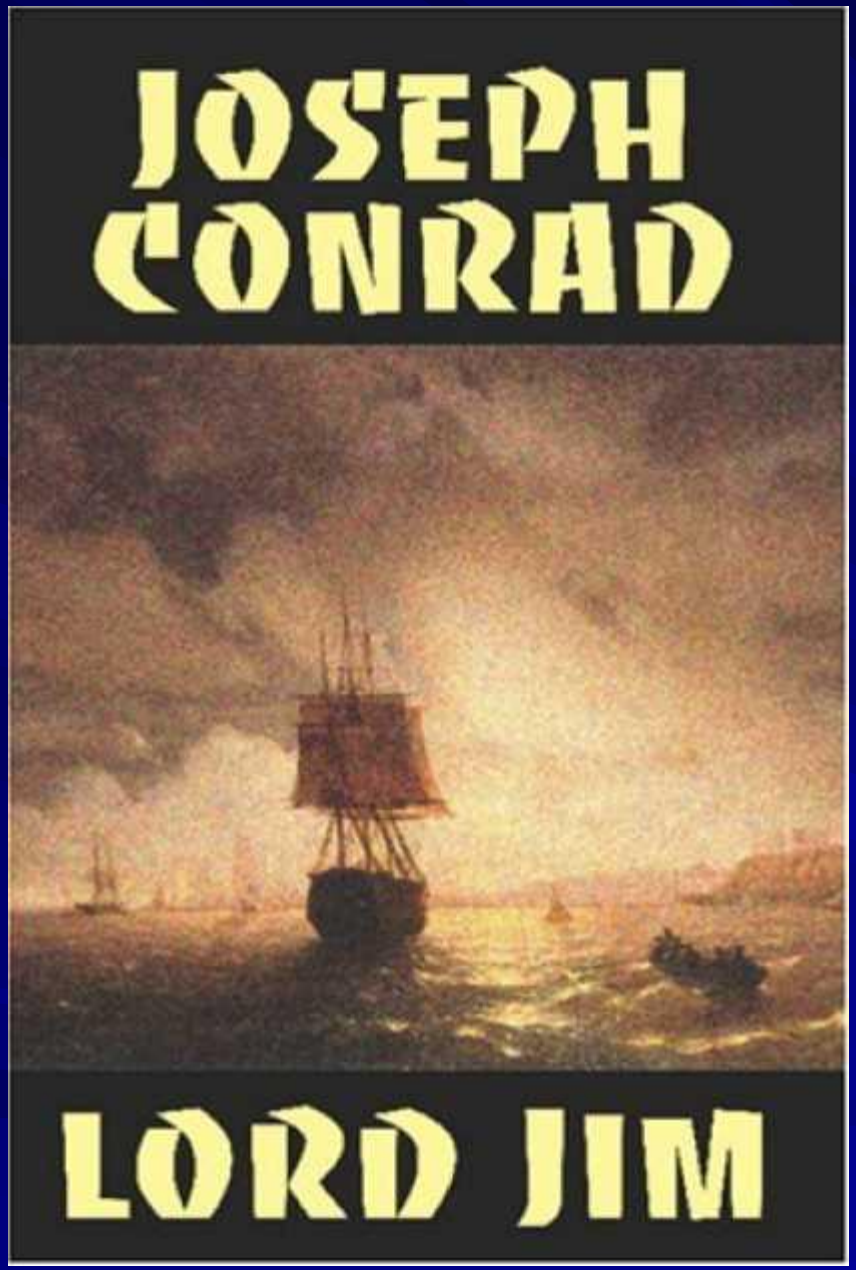
- Arose from a growing anti-hospital anti-Consultant feeling.
- Growing influence of PCGs..PCTs
- Loss of the medical hegemony
- Diabetes NSF
- QOF

The birth of ‘Community Diabetes’ is unpopular with Hospital Consultants as it grew from outside and unwelcome influences


The advent of QOF payments was the most visible manifestation of the move from hospital, money for diabetes clearly moving to primary care

Specialist

It was at this stage that some Hospital Consultants saw the need to climb down from their ivory towers and get involved at grass roots level.



Leaving a sinking ship and steering a course to terra firma or an unnecessary bail out ?

Beware the stereotype

Unfortunately, the prefix of ‘community’ to a Consultant title still carries something of a stigma for historical reasons.


CAN'T
GET A
PROPER
JOB!

Table

Age (yrs)	Mean 57.2	Range 20-85
Gender	56 male, 55 female	
Type of diabetes	12 with type 1 diabetes	
Duration of diabetes (yrs)	Mean 11.1	
HbA_{1c} (%)(mean (SD)) **IFCC HbA_{1c} (mmol/mol)**	9.78 (1.97) 83.35 (21.5)	
No. with retinopathy (n=103)	62 (60.2%)	13 maculopathy or proliferative
No. with proteinuria (n=93)	29 (28.2%)	
Therapeutic intervention	Tablet titration	43
	Insulin titration	29
	Insulin initiation	13
	GLP-1 analogues	26 (7 with insulin)
Average follow up	8.4 months	
No. of visits	2.8	

Data in this table show patient characteristics at the point of referral from primary care to a specialist clinic. Too little too late. There is plenty to do out there.

Characteristics of patients with HbA1c >7.5%

Data in this table shows that there is plenty which can be done to improve diabetes management in the community

n = 214		
Mean age	58.7 years	range 19 – 88 years
Male/female	120/94	56%/44%
Type 1	38	17.8%
single oral therapy	53	24.8%
2 oral therapies	54	25.2%
3 oral therapies	19	8.9%
insulin	88	41.1%

Reasons for poor control

Active treatment	**73 (34.1%)**
HbA1c appropriate for age	**22 (10.3%)**
Co-mormidity	**10 (4.7%)**
Declines treatment	**17 (7.9%)**
Non-attendance	**16 (7.5%)**
hypoglycaemia	**1 (0.5%)**
Obesity and insulin resistance	**8 (3.7%)**
No apparent reason	**67 (31.3%)**

These figures show that of those in primary care with poor control, there is often no good reason why this should be so

Glycaemic outcomes from clinic referral

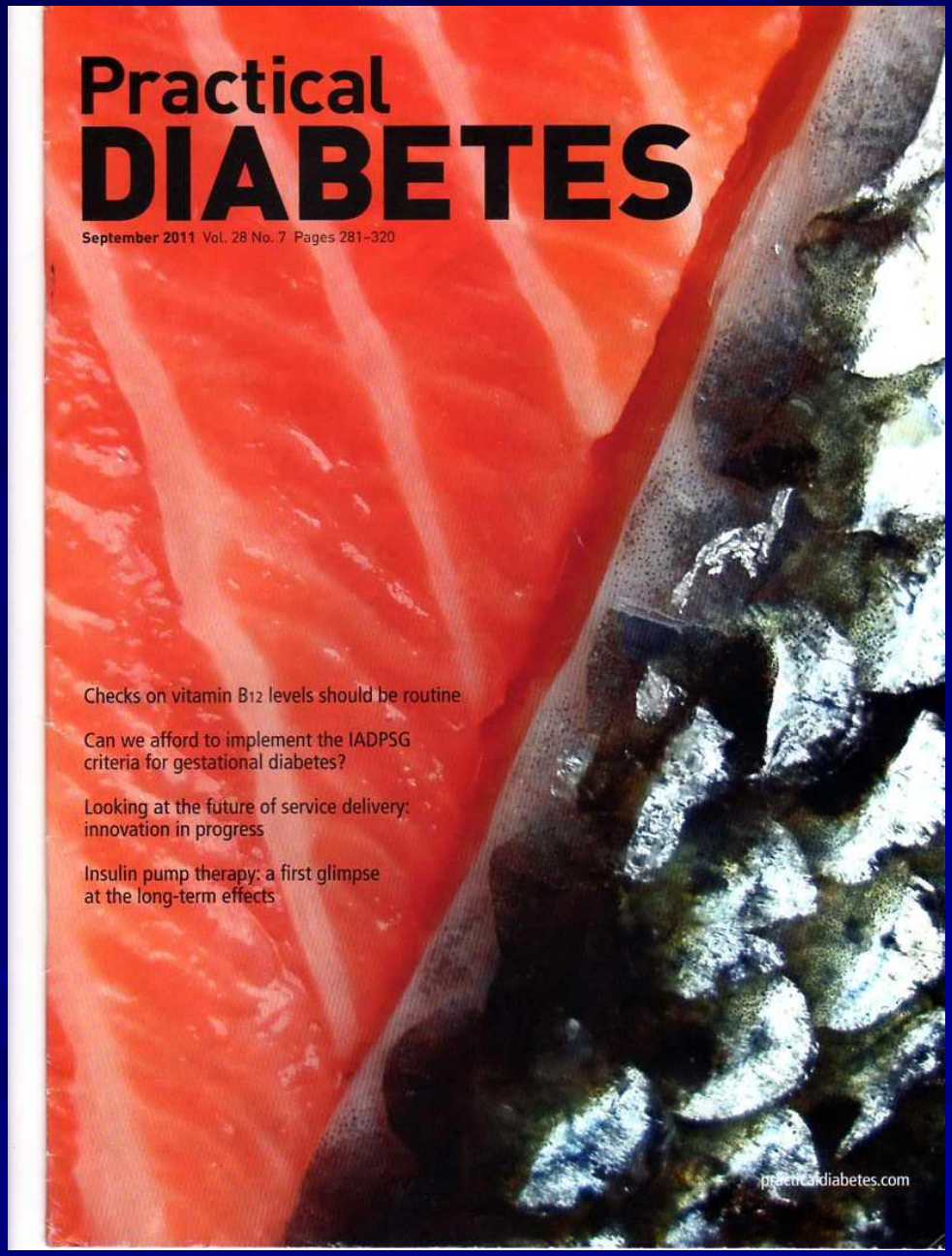
These figures show that glycaemic control can readily be improved with Consultant input.

	Baseline	Discharge or most recent	
All patients	9.78 (1.97) n=111	8.81 (1.62)	CI 0.48-1.45 p<0.01
Tablet titration	9.43 (1.80) n=43	8.19 (1.62)	CI 0.49-1.98 p<0.01
Insulin titration	9.71 (1.95) n=29	9.17 (1.20)	CI -0.34-1.42 p=0.22
Insulin initiation	10.4 (2.26) n=13	8.65 (1.46)	CI 0.19-3.31 p=0.03
GLP-1 analogues	10.28 (1.39) n=19	9.41 (1.63)	CI -0.12-1.87 p=0.08
GLP-1 analogue plus insulin	11.06 (1.51) n=7	10.28 (2.03)	CI -1.30-3.25 p=0.36
GLP-1 combined	10.49 (1.44)	9.57 (1.71)	CI 0.031-1.82 p=0.04

Opportunities in the community

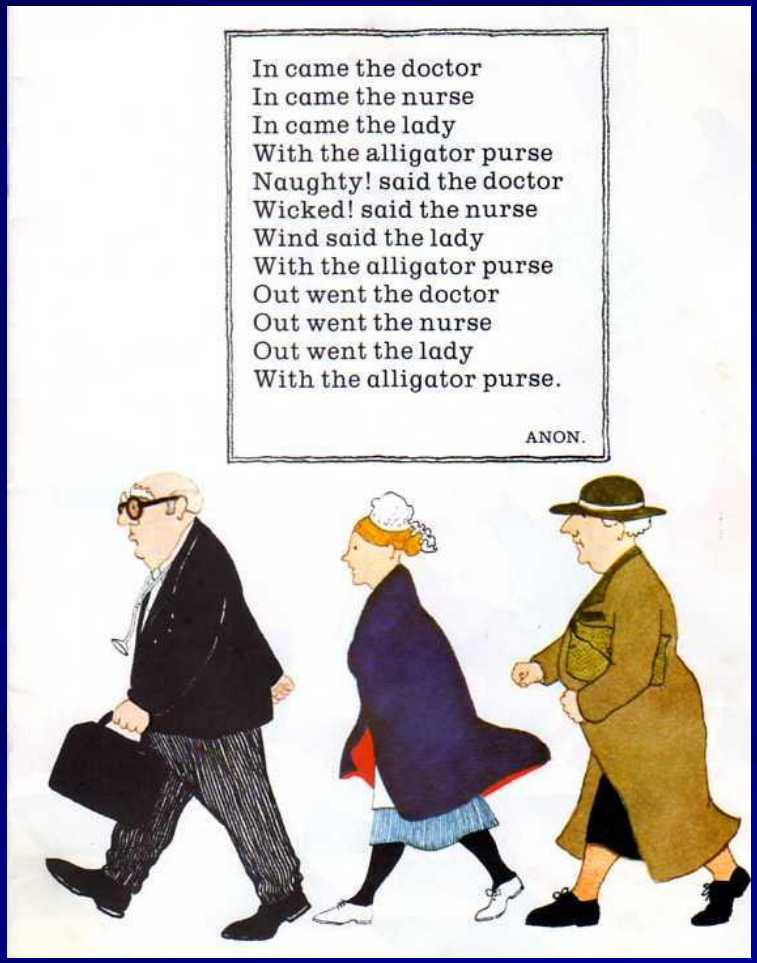
- Primary care
- Nursing homes
- Ambulance call outs for hypos
- ‘we need to see these patients but they don’t get sent to our clinics’

- Managerial opportunities



Many Consultants are seeing the opportunities of Community working as reported in this edition of PDI

In came the doctor, in came the nurse, in came the lady with the alligator purse'



Because if doctors don't do it, others will ….

Don’t just sit there

Don’t just sit there and wait. ‘You’d better start swimmin or you’ll sink like a stone’.

Conclusion

- If we don’t do it, someone else will
- We will go wherever we need to to do it
- If we have any belief in ourselves and this Association, then we believe that we will do it better than anybody else.