Diabetic care in general practice

EDITOR,—The findings of Pringle and colleagues that access to a dietitian improves metabolic control[1] confirms others' work.[2] Presumably this is why doctors want dietitians to advise people with diabetes[3,4] and why the British Diabetic Association recommends that diabetics should see a dietitian at diagnosis and yearly thereafter.[5]

It is illogical for Pringle and colleagues to conclude that it would be more appropriate for dietitians to train practice nurses than to see patients. How much and what sort of training would be needed to achieve similarly good results? Can nurses be released for training? Do dietitians have the time to train? What happens to all the patients who are not being advised because the dietitians and nurses are involved in training courses? What training in teaching do dietitians need to train others, and do they have these skills? None of these issues were covered in the study. Nor was the cost of providing services. A senior 1 dietitian's salary is comparable to that of an F grade nurse and slightly less than that of a nurse on grade G.

People with diabetes should get dietary advice from a dietitian. This gives a better metabolic outcome and represents excellent value for money. It adds up to the best service to patients, which is what it's all about.

JANICE BARRATT

Derbyshire Royal Infirmary,
Derby DE1 2QY

1 Pingle M, Stewart-Evans C, Coupland C, Williams I, Allison S, Sterland J. Influences on control in diabetes mellitus: patient, doctor, practice, or delivery of care? *BMJ* 1993;**306**:630-4. (6 March.)
2 Matthews S, Hayes TM. Effect of dietary advice on diabetic control. *Practical Diabetes* 1987;4:85-6.
3 Harris N, Roberts SH, Tapsfield WG. A dietitian in every general practice? *Practical Diabetes* 1991;8:205-6.
4 Chesover D, Tudor-Miles P, Hilton S. Survey and audit of diabetes care in general practice in south London. *Br J Gen Pract* 1991;41:282-5.
5 British Diabetic Association. *What diabetic care to expect.* London: British Diabetic Association, 1990.

Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.

EDITOR,—The conclusions drawn by Pringle and colleagues are misleading.[1] Firstly, they pick out as worthy of inclusion in their abstract that diabetic patients attending hospital had worse control than those not attending. They acknowledge that this was probably attributable to case mix and, indeed, their multivariate analysis, by not including this in the model, supports this. But why is this so worthy of comment? Surely the referral policies of general practitioners and the discharge policy of the diabetic clinic would be called into doubt if all patients with well controlled diabetes were attending the clinic.

Secondly, they juxtapose the above with the statement "Shared care did not contribute to the multiple linear regression model." This is not true. It is a mistake to equate simple attendance at a hospital clinic with shared care. The shared care schemes most fully reported[2] included four main characteristics: agreed protocols of care, follow up intervals, and referral policies; use of standard records; computer registers; and clinical and laboratory results screened by the specialist. Although Nottingham diabetes clinics are supported by a clinical information system,[3] this does not include shared care and we are not aware of other schemes for diabetics fulfilling these criteria in Nottinghamshire.

Therefore, although their findings may give some support to "concentrating diabetic care on partners with special interests in diabetics in well equipped practices with adequate diabetic support," they certainly do not—as some people may infer—provide evidence that miniclinics are better than formal shared care.

The report by Hurwitz *et al* showed that for a group of hospital attenders transferred to prompted care, care was probably more effective and diabetic control certainly no worse than in patients continuing to attend hospital.[4] Although they largely avoided the term shared care, their study lends weight to the shared care approach.

Ann-Louise Kinmonth says that several different approaches have been found to be effective in diabetic care.[5] But we need to widen the perspective. Miniclinics may have a place, but are general practitioners going to run them for diabetes and all chronic diseases? We need studies into the comparative merits of these structured forms of care and how they should be combined. In so doing, please may we try not to use the term shared care so loosely?

M SOLER

Public Health Medicine,
Greater Glasgow Health Board

R B JONES

Health Informatics,
University of Glasgow

1 Pringle M, Stewart-Evans C, Coupland C, Williams I, Allison S, Sterland J. Influences on control in diabetes mellitus: patient, doctor, practice, or delivery of care? *BMJ* 1993;**306**:630-4. (6 March.)
2 Soler M. Shared-care schemes for chronic diseases in the UK and their applicability to Spain. Glasgow: University of Glasgow, 1993. (MSc thesis.)
3 Jones RB, Hedley AJ, Peacock I, Allison SP, Tattersall RB. A computer assisted register and information system for diabetes. *Methods Inf Med* 1983;22:4-24.
4 Hurwitz B, Goodman C, Yudkin J. Prompting the clinical care of non-insulin dependent (type II) diabetic patients in an inner city area: one model of community care. *BMJ* 1993;**306**: 624-30.
5 Kinmonth AL. Diabetic care in general practice. *BMJ* 1993;**306**: 599-600.

AUTHOR'S REPLY,—Janice Barratt quite rightly highlights a considerable problem. Dietitians have valuable skills which may not easily be transferred to other members of the primary care team. And in a perfect world all diabetic patients would have regular contact with a trained dietitian.

We hesitated, however, from making such a recommendation for two reasons. Ours was a descriptive study and therefore caution should be exercised in drawing conclusions about cause and effect. Also there are practical issues—dietitians are in short supply and it would be impracticable for them to attend diabetic clinics in every practice. It seems reasonable, therefore, to explore the possibility of transferring some of their skills to practice nurses, leaving the more difficult cases for referral to dietetic clinics. However, such a transfer should be carefully monitored and evaluated and should be abandoned if unsuccessful.

M Soler and R B Jones quite correctly draw attention to the semantics surrounding the term shared care. In our study we applied the term to those patients attending hospital review in addition to the general practitioner, in distinction from those attending only the general practitioner. Since, as they state, these were the only two options in Nottingham they were the only possibilities for analysis. Readers should be aware of the sense in which "shared care" was used in our research.

MIKE PRINGLE

Department of General Practice,
The Medical School,
Queen's Medical Centre,
Nottingham NG7 2UH

Primary prevention of neural tube defects with folic acid

EDITOR,—I agree with the issues that Anna Livingstone raised in her letter on primary prevention of neural tube defects with folic acid.[1] Folic acid supplements are available, as Stephen Kiss has pointed out,[2] but to my knowledge these are all health food products. Although not blacklisted, they do not have a product licence. This means that they are not subject to the standards laid down for pharmaceuticals by the Medicines Control Agency. In addition, since these products are not medicinal products they are not normally subject to the monitoring and assessment programme undertaken by the hospital quality control service for purchased medicinal products.

I am also concerned that, because these products are not licensed, information on them will not be easily available to general practitioners. Those general practitioners who prescribe them may not be aware of the implications of prescribing such products, not least the fact that the Prescription Pricing Authority may question the prescription. I conclude that this guidance from the Department of Health will result only in difficulties for general practitioners and the women at whom the advice is aimed.

KATRINA SIMISTER

Mersey Region Drug Information Service,
Liverpool L3 6AL

1 Livingstone A. Primary prevention of neural tube defects with folic acid. *BMJ* 1993;**306**:584. (27 February.)
2 Kiss S. Prescribing folic acid. *BMJ* 1993;**306**:720. (13 March.)

EDITOR,—We are concerned about the difficulties experienced in putting into practice the Department of Health's recommendations for primary prevention of neural tube defects.[1,2]

The figure of 400 μg folic acid daily recommended for women at low risk is derived from studies carried out by the group associated with us, which used Pregnavite Forte F (Bencard), a multivitamin preparation providing 360 μg folic acid in the normal daily dose of three tablets.[3] This was effective in preventing recurrences of neural tube defects and can be prescribed in the NHS for this purpose. Since the publication of the Department