moral decision they can within the broad guidelines of their professional code. Such responsibility is a privilege of the profession. It now falls to the present generation of doctors to provide future doctors with the tools and skills to tackle increasingly complex issues, even though they are not able to prescribe solutions. Doctors have their own opinions but it is anathema to the nature of ethics for clinicians to foist these opinions on other thinking people. Where there is so much uncertainty it is both courageous and practical to acknowledge its existence. It is only by doing so that students will come to appreciate the great responsibilities that they are to take on.

DAVID SEEDHOUSE
Lecturer in Health Promotion,
University of Liverpool

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Diabetes and the general practitioner

DIABETES mellitus is known to be present in over 1% of the population[1,2] and there are probably nearly as many undiagnosed cases particularly among the elderly.[3] Diabetes is not a pleasant condition for the patient or his family. Hyper- or hypoglycaemia can precipitate acute illness at any time and there are the late complications of the disease, such as retinopathy, nephropathy and peripheral vascular disease. There is now good evidence that if the diabetes is well controlled, these complications may be prevented or delayed,[4,5] for example if retinopathy or foot ulceration are detected early and properly treated, blindness or amputation can usually be avoided. Renal failure can now be treated with ambulatory peritoneal dialysis or renal transplantation. In the last decade there have been important improvements in the treatment of diabetes — new and better insulins, fresh approaches to insulin administration, improved oral hypoglycaemic agents and new ideas about diets for diabetics.

Clearly, good care has a lot to offer the patient with diabetes, but what constitutes good diabetic care? First, there is early diagnosis. The general practitioner with a list of 2000 patients probably has 20 undiagnosed diabetics. How can he recognize them? The obese, those with a strong family history of diabetes and women who have had big babies, are those most at risk. When a new diabetic is diagnosed, treatment must be started. This does not necessarily mean medication. Diet features in all treatment programmes and is of great importance.[6] It is now realized that patient education is a key factor in the management of diabetes.[7] If patients are to keep their diabetes well controlled they need to know a great deal about the condition and the factors that influence the blood glucose — diet, tablets or insulin and exercise. The next stage in diabetic care is regular follow up to check on weight, blood glucose level and measurement of glycosylated haemoglobin, the latter to see what diabetic control has been like over the previous six weeks. Studies have shown that the education process is needed not just at the start of treatment, but should be repeated and updated from time to time. In the long term a regular check perhaps once a year must be made for early evidence of complications — the eyes for retinopathy, the urine for albuminuria, the blood pressure, the legs for evidence of peripheral neuritis and the feet for the risks or presence of ulcers.

A key question is who is to provide care for the diabetic patient. The average health district will probably have 2000 or more cases. The district diabetic clinic will be unable to cope satisfactorily with this number, although the consultant in charge would try to deal with the problem patients and those with complictions. Furthermore, many diabetics would prefer to be supervised by their general practitioner. There are problems, however. The general practitioner may have difficulty getting advice for his patients from a dietician, although an increasing number of health districts employ a dietician to see patients referred by their general practitioner. The education of the patient is another problem. Experience has shown that nurses can be the best diabetes educators and three quarters of the health districts now have specialist diabetes nurses.[8] In some larger practices one of the practice nurses may take a special interest in diabetics and obtain the training needed to advise these patients. The annual check on the retina may present a problem but ophthalmic opticians may be able to undertake eye screening for diabetic retinopathy that may need laser treatment.[9] Another problem is that the general practitioner cannot prescribe the blood glucose testing strips for his patients — a point that is under continuing discussion between the profession and the government.

A real difficulty is that some general practitioners are inadequately informed about the new developments in the management of patients with diabetes and a number are reluctant to learn about them. The Royal College of General Practitioners has recently produced a valuable information pack to help them. In many health districts, the consultant responsible for diabetic care has actively sought to enlist the help of general practitioners and to encourage them to take a meaningful part in the care of the diabetics in their practices.

Diabetes is a real challenge, and recent developments have the potential to improve the outlook for the diabetic patient. It is not possible for the hospital consultant to shoulder the entire burden of caring for the diabetics in any district, indeed it would be quite wrong for him to attempt to do so. The majority of diabetics can be looked after as well or better by their general practitoner and in most instances would prefer this. The challenge is for general practitioners to show that they can do at least as good a job as the hospital clinic.

JOHN NABARRO
Chairman, Executive Council,
British Diabetic Association

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The information pack on diabetes can be obtained from the Central Sales Office, Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU. Price £5.00 to members, £6.00 to non-members.