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## Emergency delays

EDITOR,—Luisa Dillner reports that one of the reasons for delay in admitting patients seen as emergencies in the accident and emergency department is that doctors from the teams on take are in theatre or outpatient clinics.<sup>1</sup> This situation could be improved if accident and emergency medical staff rather than ward doctors were responsible for deciding which patients should be admitted. In addition, emergency treatment could then be started by the accident and emergency staff.

The perceived advantages of ward doctors going to the accident and emergency department are that they prevent inappropriate admissions and that diagnostic accuracy is increased. A recent study of 1200 patients in Belfast compared admitting practice in two accident and emergency departments with similar staff, number of patients, and catchment population. In one department patients were seen and admitted by the accident and emergency doctors; in the other the decision to admit was taken by the team on take. There were no significant differences in rate of diagnostic error or inappropriate admissions between the two departments. A survey of 153 consultant led accident and emergency departments throughout the United Kingdom showed that the decision to admit was the responsibility of the accident and emergency doctors in only 6%. Clearly, detaining medical and surgical patients in the accident and emergency department for assessment by the ward doctor has no benefit to either the hospital or the patient, and the accident and emergency doctors should be given admitting rights.

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## Antenatal screening for cystic fibrosis

EDITOR,—Zosia H Miedzybrodzka and colleagues' claim that stepwise screening for cystic fibrosis is better than couple screening is unjustified.<sup>1</sup> Antenatal screening for cystic fibrosis should minimise the number of women identified as being at high risk for a given proportion of affected pregnancies detected and should ensure that a diagnostic test is available for everyone defined as being at high risk. Stepwise screening fails on both counts.<sup>2</sup> It identifies about 30 times more women as being positive on screening without increasing detection and therefore necessitates more counselling to cope with the associated anxiety. About 3% of screened women will be identified as carriers, but their partners will not have a detectable cystic fibrosis mutation. These women are told they are at risk but cannot be offered a definitive diagnostic test.

The average anxiety score in women found to be positive was slightly higher after couple screening than after stepwise screening (35.4 v 32.1 compared with 34.2 v 32.7 respectively at recruitment). This is minor compared with the initial acute anxiety (average score 52.3) among the 3% of

women with positive results of stepwise screening. To dismiss their anxiety by saying that "this dissipated after receiving a negative result for their partners" is unreasonable.

The paper concludes that stepwise screening provides more "genetic information." Providing information is an advantage only if it leads to specific action that would not otherwise have been taken. Providing excess information can invite unsolicited interventions, such as tracing of relatives to determine their carrier status, with unpredictable medical and financial implications. It could be costly and upsetting while conferring little or no practical health benefit. Screening programmes should be as simple and economical as is necessary to achieve their intended aim in the population that has explicitly accepted the invitation for screening. Additional advantages should not be presumed. They should be made explicit and quantitatively assessed in both medical and financial terms.

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## Short stature and diabetic nephropathy

EDITOR,—Rossing and colleagues conclude that short stature is related to the development of diabetic nephropathy in men and speculate that influences in early life could account for their findings.<sup>1</sup> This interpretation is based on the assumption that adult height is determined solely by factors operating in utero or early life. But height is also related to parental social class<sup>2</sup> and has been used as a proxy for adult socioeconomic status.

We have also found a relation between height and albuminuric status in a European study of the complications of insulin dependent diabetes but place a different interpretation on these findings. Patients aged 15-60 with insulin dependent diabetes were recruited from 31 European centres.<sup>3</sup> Age at completion of education defined socioeconomic status in three groups:  $\leq 14$ , 15-18, and  $\geq 19$ . These analyses are restricted to people aged  $\geq 25$  to ensure that all those who would receive higher education had had an opportunity to start. Albumin excretion rate was calculated from a timed 24 hour urine collection. Macroalbuminuria was defined as a rate of  $\geq 200$   $\mu\text{g/ml/min}$  and microalbuminuria as a rate  $\geq 20$   $\mu\text{g/ml/min}$  but  $< 200$   $\mu\text{g/ml/min}$ .

Men with macroalbuminuria were significantly shorter than those without (table). This relation was present, but not significant, in women. The most educated men were also the tallest (171, 175, and 176 cm respectively,  $P=0.0001$  for trend). This trend was not found in women (161, 164, and 163 cm respectively,  $P=0.2$  for trend). When a term for educational status was included in the model the relation between height and

## Relation between albuminuric status and height (cm) in EURODIAB insulin dependent diabetes mellitus complications study

Albuminuric status	Men (n=1217)	Women (n=1170)
Adjusted for duration of diabetes:		
Normoalbuminuric	175	163
Microalbuminuric	175	163
Macroalbuminuric	173	161
P value for trend	0.03	0.8
Adjusted for duration of diabetes and educational status:		
Normoalbuminuric	174	163
Microalbuminuric	174	162
Macroalbuminuric	173	161
P value for trend	0.1	0.8

albuminuric status was considerably attenuated in men (table). Adjustment for centre did not alter these relations.

We showed that height was related to nephropathy in men and confirmed that height was also related to educational status, a proxy for social class in adults.<sup>2</sup> Educational status accounted for much of the relation between nephropathy and height. Longitudinal data are required before we can jump to hasty conclusions about influences in early life and diabetic nephropathy.<sup>4</sup>

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## Shared care in diabetes

EDITOR,—We agree with Amanda J Sowden and colleagues' conclusion that evaluation of shared care must take into account many factors that influence effectiveness and efficiency, but the authors do not address the reasons why current systems of care fail.<sup>1</sup> The main problem with traditional management of chronic conditions is that the provision of care is not matched to need. Some patients receive a lot of care, a lot of patients receive some care, while other patients receive little or no care.<sup>2</sup> Many patients are lost to follow up. A good system of shared care should rectify this imbalance by providing, efficiently, the best possible care with maximum coverage of the population at risk. Without such long term follow up schemes, determining what is best is not possible since data on outcomes are usually not available. In addition, to focus only on the clinical outcomes of those who are receiving care is to confuse assessment of the effectiveness of the delivery of care with that of the clinical care itself.

Two recent rigorous trials of similar models of shared care for diabetes<sup>3</sup> and hypertension<sup>4</sup> showed that shared care was associated with lower drop out rates and was more cost effective for the patient. Cost to the patient is likely to be an important determinant of continuity of care. The hypertension study and an earlier study of shared care for thyroid disease<sup>2</sup> showed cost effectiveness for the health service and a reduction in the number of patient-clinician contacts while the standard of